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ABSTRACT

Intended primarily for professionals teaching early childhood and infant intervention courses, this handbook presents an overview of child care as both a support to families and an economic necessity, meeting changing and dynamic needs. Child care settings and types of care are discussed, along with quality indicators, licensing, and provider safety and training. Suggestions are offered for locating care for families and employers, as well as a discussion of the national network of resource and referral centers. Also covered are the diversity of child care needs and health concerns and the many funding resources available to support child care and related needs. The eight chapters are: (1) "Child Care in the Nineties: Diversity and Changing Needs" (Carol Baglin); (2) "Child Care Settings and Targeting Care for Quality" (Carol Baglin); (3) "The Role of Licensing in Ensuring Quality Child Care" (Roberta Ward); (4) "Healthy Child Care" (Janeen Taylor and W. S. Taylor); (5) "Meeting the Need: Child Care Resource Centers" (Sandra Skolnick); (6) "Trained Providers and Quality Curriculum" (Christina Mandelson); (7) "Promising Practices in Programming" which contains four essays--"Programming for Children Who Are HIV+ or Exposed to Substance Abuse" (Clare Siegel), "Serving the Needs of Low Incidence Children: Local School and Community-Based Model" (Judy Kanigel), "Child Care for Children with Complex Medical Needs" (Polly Harrison and others), "Child Care: A Setting of Early Intervention (Joan Karasik); and (8) "Finding Funding: Sources of Resources for Child Care" (John Surr). References are included with each article. Six appendixes contain a variety of additional resources including National Association of Child Care Resource and Referral Agencies, federal programs, funding resources, and selection criteria for child care settings. (TJQ)

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on

CHILD CARE FOR YOUNG CHILDREN

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Carol Ann Baglin
Michael Bender

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HANDBOOK ON QUALITY CHILD CARE FOR YOUNG CHILDREN

SETTINGS, STANDARDS, AND RESOURCES

HANDBOOK ON QUALITY CHILD CARE FOR YOUNG CHILDREN

SETTINGS, STANDARDS, AND RESOURCES

Edited by
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PREFACE

Few concerns in recent years have drawn such public attention and controversy as the need for providing quality child care. News programs and Specials have candidly revealed the abuses and shortcomings of poorly operating child care systems. In some instances, these programs are portrayed as being out of control, with few safeguards or enforceable standards. Adding to this dilemma is the inexorable increase of both parents having to work to provide the necessities or extras that help better define quality of life. In essence, the need for quality child care programs continues to grow, as are the awakened fears and questions associated with quality issues, availability of affordable services, safety concerns, and potential for child neglect and abuse.

The *Handbook on Quality Child Care for Young Children: Settings, Standards, and Resources* presents an overview of child care (see Figure) as both a support to families and an economic necessity, meeting changing and dynamic needs. An extensive analysis of child care settings and types of care is detailed, along with descriptions of quality indicators to evaluate child care. Licensing of child care as a governmental function is analyzed, along with the issues of provider safety and training. Suggestions for locating care for families and employers are available as well as a discussion of the national network of resource and referral centers. The diversity of child care needs and the important area of health concerns are covered to provide the reader with the knowledge necessary to create a child care environment which is available to many children and supportive of diverse specialized needs. A remarkably comprehensive review of the many funding resources available to support child care and related needs is presented in a usable format, detailing federal, foundation, and corporate supports.

This book has primarily been written for professionals teaching early childhood and infant intervention courses, as well as community college instructors in child development. Educators, clinicians, and health professionals working in the area of child care and family services will also find in this unique resource critically needed information that should prove helpful in further developing and expanding their programs. Also, those involved with the new requirements and expansion of Head Start Programs

will be able to use this information as a basis for coordinating and linking Head Start to quality child care programs. Finally, parents and consumers will be able to use much of the *Handbook*'s content to develop pertinent questions that help evaluate the quality of community child care.

For years, child advocates have recognized the importance of placing infants, toddlers, and young children in nurturing child care environments. For parents, the knowledge that their child is in a safe and appropriate program allows them to feel reasonably

relaxed. There is great solace in knowing that someone you trust is caring for your child. Unfortunately, finding quality child care, and once found, affording it, is not always easy. We continue to be shocked with the escalating number of "latchkey" children who have no adult supervision during long hours of the day. Many of these children now have taken on the expanded role of watching younger siblings. In essence, we have children watching children in a high-risk situation that all too often ends in tragedy.

For many parents, local co-ops, drop-in centers, and similar arrangements have constituted one level of child care, while baby-sitters, nannies, and relatives have offered another. More formal programs such as those found in Nursery schools and private and public agencies also have proliferated over the last few years, but often at a cost way beyond most average wage earners.

The search for appropriate and quality child care can be a traumatic experience. The identification and selection process is usually begun by asking friends for suggestions or reviewing information on a specific program. In some instances, accrediting agencies or health departments are contacted to find out if any problems have been reported at a specific center. While all of these precursors of selecting a quality program are important, they do not substitute for one's personal review and feelings about a program. In addition, and unfortunately, one can no longer place too much emphasis on recommendations from other people about a specific program in which their child might have been enrolled. In many instances, and especially in child care programs, teachers or assistants change or leave on a regular basis due to poor salaries, little opportunity for advancement, or inflexible working hours. Unless one feels assured those they talk with are presently and actively engaged in the program they are discussing, their information should be weighed carefully with other types of information.

Why aren't parents more actively involved in carefully selecting their child's programs? Why do many individuals spend more time selecting an appliance or the accessories on a car than selecting a quality program? Why do they trust their children in some instances with strangers they know little about? Why do they not ask questions which might reveal strengths and weaknesses of a program? What do they do when they suspect something might be inappropriately going on in their child's program? These questions and others helped identify a need for professionals to have in one resource a *Handbook on Quality Child Care for Young Children: Settings, Standards, and Resources* which would contain information they could use in their own practice, as well

as share with parents and other interested parties. Although numerous early childhood journals continue to present exciting and innovative material, not everyone has access or can afford to subscribe to these monthly or quarterly publications. Therefore, there was a need to have in one comprehensive source, information which would enable a person to understand what to be aware of, and look for, in quality child care programs.

The editors of this resource, Carol Ann Baglin, the Director of Prevention and Early Intervention for Young Children for the State of Maryland and national authority on services for young children, and Michael Bender, Professor of Education and Pediatrics at The Johns Hopkins University and School of Medicine, searched for child care practitioners who could contribute information to the *Handbook* which best reflected the questions they were being asked in their daily practices. The individuals selected worked closely with children, parents, and agencies and possessed knowledge and content which was felt to be crucial in developing this comprehensive resource.

Carol Ann Baglin introduces the resource by providing, in Chapter 1, a view of what child care has been and will be in the years ahead. This prospective view clearly indicates that diversity and changing needs continue to be the major criteria and framework for program selection and development. In Chapter 2, Baglin describes the issues surrounding types of settings and how we must target care to meet specific needs. Throughout this chapter, the reader is encouraged to question how we evaluate child care through quality indicators.

Roberta Ward, the Assistant Director for Program Standards of the Maryland Child Care Administration and an attorney specializing in child care licensing and standards, has written Chapter 3 which provides information concerning licensing, state regulations, environmental, health, and staffing standards. Ward also provides a candid discussion of the difficulty of providing oversight of programs and sanctions, when program discipline is in order.

Chapter 4 addresses the area known as "healthy child care" and is written by Janeen Taylor, who is on the Adjunct Faculty of The Johns Hopkins University and with the Maryland Infants and Toddler Program, and W. S. Taylor, a physician at the Washington Hospital Center in Washington, DC. This chapter includes a broad description of why infectious diseases are a problem in child care settings and what diseases are of major concern. This is followed by a discussion of what can be done to

minimize the transmission of communicable diseases in group settings for young children. Other issues considered in this chapter include the role of environmental factors, staff health, and the need to provide administrative guidance. This chapter provides much of the necessary information one needs to set up a child care program and includes all the contemporary safeguards one needs to ensure healthy child care.

Sandra Skolnick, the Executive Director of the Maryland Committee for Children, presents information in Chapter 5 about the Child Care Resource Centers (CCRCs). Unfortunately, most professionals as well as others often are unaware that these centers, which provide referrals and support services for the child care delivery system, exist. Yet, they can provide invaluable service in locating child care in the community and providing training resources. For example, Skolnick describes how to begin the child care search process, what to ask of the prospective provider, and what to look for during a visit. Information also is provided on how to operate a child care program, including potential outside funding sources for providers and families.

Chapter 6, written by Christina Mandelson who is the Early Childhood Specialist and Training Coordinator for the Henry M. Jackson Foundation for the Advancement of Military Medicine, offers the reader information on two critical components of providing quality child care. These components are the training of providers and the curricula they use. Mandelson reveals that it is not necessarily experience alone which makes a good child care teacher, but the specialized training which parallels it. She goes on to discuss the types of training available and how supervision and mentorship are essential components in quality training programs. The chapter concludes with a discussion of the need for specialized early childhood teacher certification and the quandary existing when generically certified (birth to 8 years) early childhood teachers are placed in programs for which they have little, if any, practical experience. Training content also is discussed in terms of the need to establish a certifiable core of knowledge and skills which would permeate all early childhood programs and the need to provide intervention and training services in the "natural environment" of the children and families which are age and individually appropriate.

Chapter 7 provides an overall framework for Promising Practices in Programming. It contains four sections, each authored by one or more individuals. Clare Siegel, a Coordinator

of an HIV Project of the Baltimore City, Maryland *Head Start* Program addresses the escalating problem of programming for children who are HIV+ and those exposed to substance abuse. She presents the point that HIV disease, as with other chronic illnesses, needs to be viewed as a continuum from time of infection through symptomatic periods, to death. This is especially important to those working with this population, as children who are symptomatic may feel well at times and sick at other times. Siegel explains symptoms and types of medical treatments and concludes the section by suggesting that HIV children and the issue of exposure to illegal drugs are often intertwined. Because many mothers of HIV babies have had sexual contact with drug abusers, readers are advised that it is important there be an awareness of the types of drugs used as one looks for adverse effects.

Judy Kanigel, a former public school principal, then presents a description of how to serve the needs of low incidence children with disabilities through a local school and community-based model. In this personal account, Kanigel also reports the policy changes that have occurred over the last several years which have addressed children with special needs.

Polly Harrison, Director of Child Health Services for the Maryland Department of Health and Mental Hygiene, Anne Paradiso, the Program Coordinator for the Family and Infant Care Center, Ellen B. Widoff, the Director of Children Services at the Association for Retarded Citizens, and Genie L. Wessel, consultant for child health services, provide the reader with information concerning child care for those children who present with complex medical needs. The authors outline the specifics one should seek in a quality program for this population of children. These include understanding the philosophy supporting the program, site and accessibility considerations, staffing and ratio requirements, and the need for family support and training.

The chapter concludes with a section by Joan Karasik, a longtime advocate for the Association for Retarded Citizens, who presents child care as a setting for early intervention. In this section Karasik describes the development of the Interagency Infant and Toddler programs, the importance of the natural environment, and the barriers presented in seeking quality child care. Of special importance to the reader is that the barriers are not discussed in isolation, but with a description of strategies which may serve as possible starting points for solutions.

Chapter 8, Finding Funding: Sources and Resources for Child Care, will be of special interest to those seeking financial

support for their programs. In this chapter John Surr, an attorney and advocate for young children, provides a wealth of information and a comprehensive list of federal funding program descriptions, as well as descriptions of national foundations and corporate giving programs. Also included are numerous resources to contact regarding the funding of national child care initiatives; funding for buildings, toys, and materials; as well as funding for church-affiliated child care.

This *Handbook on Quality Child Care for Young Children: Settings, Standards, and Resources* concludes with six appendixes that list additional resources which readers may wish to have as they begin or expand their programs. This includes the list of State Resource and Referral Agencies provided by the National Association of Child Care Resource and Referral Agencies (NACCRRA), listed by state; a listing of national organizations and resources; an annotated bibliography of books, journals, and videos; a directory to federal programs and resources; annotated funding resources; and information to assist in selecting quality child care This information coupled with the preceding chapters should enable the reader to have, in one place, a comprehensive list of resources to use in daily practice.

Much has been said about the need for early childhood programs to be inclusive and move as quickly as possible to being family centered, developmentally appropriate, and of full-day duration. Programs developed as a result of infant and toddler legislation, Head Start initiatives, and proactive advocacy are a step in the right direction. It will always take information and insight to help decide what is an appropriate and acceptable program for our most cherished resource, our children. Hopefully, *Handbook on Quality Child Care for Young Children: Settings, Standards, and Resources* will help in making these lifelong decisions.

DEDICATION

To Samantha and Sarabeth, a promise to do the very best I can to ensure quality and safety in child care settings for all young children.

CAB

This book about children is dedicated to a master educator, Sue Valle, and her preprimary team of teachers. Sue's extraordinary efforts to make children feel comfortable and wanted as she imparts educational wisdom will never be forgotten.

MB

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We would like to acknowledge the many dedicated professionals in the child care provider community who, on a daily basis, create quality environments for young children. In addition, we recognize the important role of the community colleges in providing the instruction, leadership, and support to the early childhood community, advancing the preparation and quality of child care professionals.

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Special thanks go to Dr. Nancy S. Grasmick for her enduring commitment to young children and her leadership in promoting quality education and child care throughout the nation.

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CHAPTER 1

CHILD CARE IN THE NINETIES: DIVERSITY AND CHANGING NEEDS

CAROL ANN BAGLIN

Child care in the United States is receiving an unprecedented amount of nationwide attention. The population is finally beginning to realize the importance of adequately caring for young children as part of society's concern and not just a mother's worry. Whether this attention is based on economic necessity or moral awakening, the care of children is now being planned and funded with a promise of enriched childhoods for our youngest citizens.

Child care includes regulated child care arrangements, playgroups, drop-in centers, baby-sitters, nannies, relative care, or any arrangement that provides supervision for children consistent with legal and safety requirements. Some children may receive multiple forms of care in one day, including combinations of child care, preschool, kindergarten, Head Start, special education, or other early childhood programs.

Child care has become critically important for families, providing services in a wide array of settings. Many of these settings may be funded through the diverse resources of government, employers, and the family. It has been the impetus of mothers

who, as permanent and significant members of the labor force, have had an impact on and changed the nature of the debate over child care during this century.

HISTORICAL PERSPECTIVE

The chronicle of child care offers an interesting account and context for many present-day issues. Early foundling homes were established in Milan in A.D. 787 as an alternative to infanticide, and in 1280 Pope Innocent III founded a children's hospital in Rome to stop women from throwing their children into the Tiber River. In 1294, the asylum of San Gallo was established to prevent crimes against infants in Florence (Hewes, 1975).

In early societies children were tolerated until they became useful contributors. By the seventeenth century children were more charitably thought of as "children of God" and, by the eighteenth century, parents fretted over their children's health and safety and began to send their children out of the cities to protect them from illness and war. The earliest known institution that combined child care with educational goals appears to have been started in 1769 by John Frederic Oberlin, a pastor in northeastern France (Hewes, 1975). The Industrial Revolution in Europe pressed women into factories, creating the need for child care. Dame schools, run by elderly and impoverished women, provided care concurrently with some limited instruction. Child labor was prevalent during this time, and children were frequently indentured or apprenticed at an early age.

In the early 1800s infant schools were established in England and became the basis for subsequent models of early childhood education. During this time governesses began to provide instruction to children, freeing aristocratic mothers to do volunteer work. By 1851 there were 25,000 governesses in England (Hewes, 1975).

In early American history homeless children were taken in by their relatives, until asylums and institutions were specifically built in the 1800s for this purpose. Some families put their children in schools at an early age for discipline and education. In the middle of the nineteenth century, the spread of industrialization to the United States forced many young children into the labor force. However, immigration and advances in technology decreased the need for child labor at the same time the Child Study Movement, led by G. Stanley Hall (Hewes, 1975), made the public more aware of the needs of young children. It was the neglect of young children that led to the expansion of day nurs-

ery programs. During this time day nurseries were being established in response to the needs of poor women having to work and the awareness that children needed nurturing and a variety of supportive activities. In 1898 some of the day nurseries joined to form the National Federation of Day Nurseries. At this time the kindergarten movement, inspired by the teachings of Froebel, stressed education and was provided to the children of the more educated and well-to-do families (Kagan, 1991). In the early 1900s the kindergarten movement was taken over by the public schools, resulting in a benefit to the broader society.

During the Depression there was an increase in the use of nursery schools to assist the children of poor families. President Franklin D. Roosevelt persuaded Congress to authorize funds to establish nursery schools, opening 3,000 nursery schools, serving an estimated 65,000 children. These nursery schools targeted children's health and nutritional needs, providing minimal early childhood education. Many of these nurseries were housed within public schools and provided full-day care. With the onset of World War II there was widespread need for child care for working mothers, and many of the remaining nursery schools converted to child care centers and included an educational component (Wheat, 1989). With the end of the war and the return of men to their normal employment and women to their traditional roles, interest in child care waned. Federal assistance for child care re-emerged on the national agenda in 1963, when President Kennedy expanded child care services by proposing legislation and funding. This renewed interest in education and support for young children led to the Head Start program in 1967. Other early childhood education and child care programs targeting children of welfare recipients began to proliferate, providing preschool and child care services. By the 1960s and 1970s, a patchwork of public and private early childhood education and child care services had become a permanent part of the network of care for young children.

In 1970 the White House Conference on Children voted child care the number one problem facing American children and families. In 1971 the Child Development Act would have established a national network of child care centers, but it was vetoed by President Richard Nixon (Zigler & Gilman, 1993).

In the 1980s Congress enacted legislation that began to target young children and their families with the enactment of comprehensive early intervention services. Figure 1–1 illustrates the transitions in the United States from institutional care to comprehensive early childhood programming and child care.

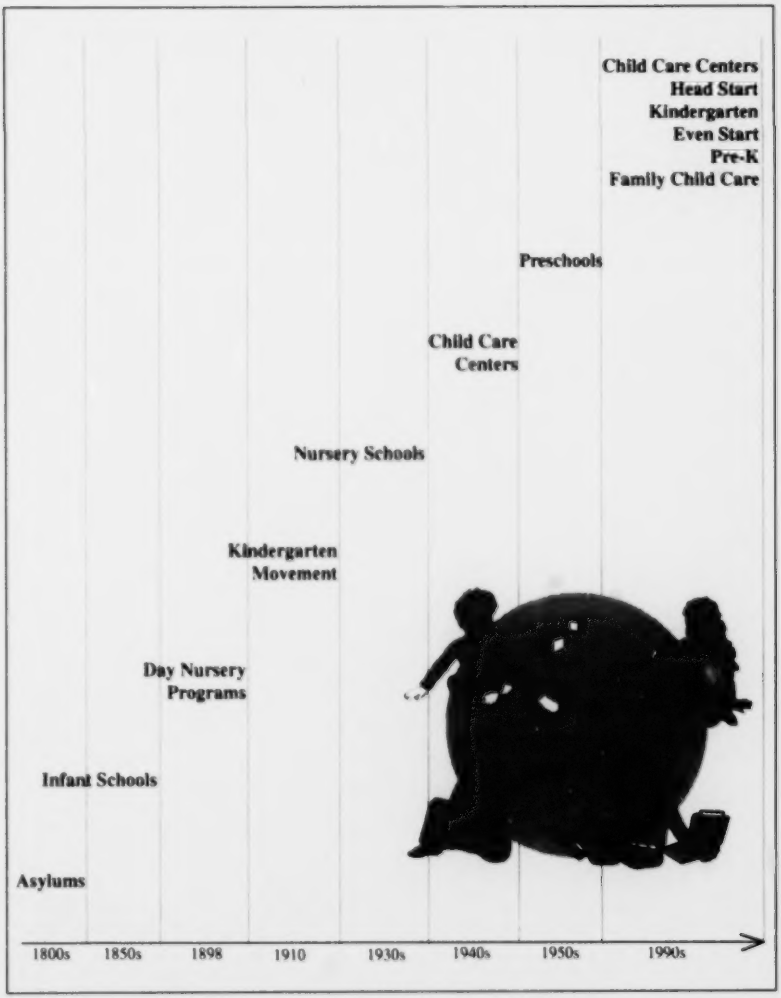

Figure 1–1. Transitions in child care in America.

CHANGING FAMILIES, CHANGING NEEDS

The family of the 1990s is dynamic, changing, and emerging as a force for change in child care. In 1991 just over one third of all families consisted of a married couple with children, and nearly one in eight families was headed by a single parent in 1991, dou-

ble the proportion found in 1970 (Ahlburg & DeVita, 1992). These parents need child care whether they are working or not. Parents are also attending school in greater numbers, participating as volunteers in their older children's schools, or seeking leisure activities to enhance their lives. All of these activities require the availability of quality child care. Recipients of public assistance are now required to participate in work training or education programs and require access to care for their young children while working or in school. Many families view child care as an opportunity to provide enrichment in their children's lives, as well as a major obstacle in achieving their personal goals.

Data from a 1988 National Health Interview Survey (NHIS), indicates that 68 percent of U.S. children 5 years of age and under had been in a child care arrangement at some point in their lives, ranging from 56 percent of children under 2 years of age to 80 percent of children ages 4 to 5. Children with annual family incomes of $40,000 or more were far more likely to be in child care than children with family incomes under $10,000. The percentage of children cared for in regular child care increased with the mother's educational level, from 47 percent of those whose mothers did not complete high school to 78 percent of those whose mothers had attended college (Dawson & Cain, 1990). Table 1–1 shows that the most commonly used child care arrangements for children 5 years of age and under were nursery schools or preschools, then care provided by a nonrelative in a home other than the child's, followed by care provided by the father.

Birth expectations for women are at the level of replacement fertility, with women 18 to 34 years of age in 1990 expecting to have an average of 2.1 children in their lifetime. Fifty-three percent of women 15 to 44 years old with newborn children participated in the work force in 1990, up from 38 percent in 1980 and 31 percent in 1976 (Bachu, 1990). The majority of first-time mothers ages 18 to 44 with infants are now in the workforce (Bachu, 1990). College-educated, first time mothers had the highest labor participation rates, with 68 percent of those having college degrees returning to work within a year after birth. Older mothers (59 percent) were more likely than younger mothers (43 percent) to return to work. Caucasian mothers increased their labor participation rate to 54.5 percent, while the rate for African American mothers remained unchanged at 47 percent of the women with children.

By the mid 1990s it is expected that two thirds of mothers with preschool-age children will be in the labor force. Younger children

Table 1–1. *Child Care Status*

Characteristic	Number of Children (in thousands)	Ever Cared For (percent[3])	Currently Cared For (percent[3])
All children[1]	22,107	647.7	60.0
Age and School Status			
Under 2 years	7,535	55.6	50.1
2–3 years	7,389	69.5	62.4
4–5 years, not in school	4,709	80.4	72.7
4–5 years, in school	2,304	74.3	57.4
Race			
White	17,828	68.5	60.9
Black	3,336	63.5	54.9
Hispanic Origin			
Hispanic	2,537	59.8	53.3
Non-Hispanic	18,644	68.8	60.8
Family Income			
Less than $10,000	3,046	47.6	36.7
$10,000–$24,999	6,279	66.4	57.9
$25,000–$39,999	5,550	73.3	65.5
$40,000 or more	4,905	79.2	73.7
Geographic Region			
Northeast	4,055	60.6	55.3
Midwest	5,675	70.5	61.8
South	7,642	69.3	60.1
West	4,735	67.8	61.5
Place of Residence			
MSA:			
Central city	7,038	65.1	57.3
Not central city	9,886	69.5	62.5
Not MSA	5,183	67.8	58.7
Mother's Education			
Less than 12 years	3,959	47.4	37.6
12 years	9,071	66.3	58.5
More than 12 years	9,078	77.8	71.0
Mother's Employment Status			
Employed[2]	10,174	99.6	98.9
Not employed	10,136	34.9	20.1

[1] Includes races other than white or black and unknown origin, income, education, and employment.

[2] Includes looking for work and not in the labor force.

[3] Standard error ranges from 0.1 to 2.6.

Notes: Care arrangement includes nursery school, preschool, and kindergarten extended day care. Percents exclude unknown values for ever and current care from numerator and denominator; numbers of children include those with unknown values. MSA is metropolitan statistical area.

Source: From Dawson D. A., & Cain, V. S. *Child care arrangements: Health of our nation's children, United States, 1988. Advance data from vital and health statistics* (No. 187). Hyattsville, MD: National Center for Health Statistics. Reprinted by permission.

are frequently cared for in less formal arrangements, relying on relatives, family day care, or in-home care. Mothers of children under the age of 6 are the fastest growing segment of new workers in the labor force and will require care for approximately 11 million of their children. Frequently, many children experience unsettling changes in their child care arrangements, depending on parental need and stability of provider setting. There are 1.3 million "latchkey children" between 5 and 14 years left on their own each day (Richman, 1992). Many of these will be at high risk for drug use, alcohol abuse, early sexual activity, and school drop-out.

The increase in divorce and single parent families means that more than half of all Caucasian children and three quarters of African American children under 18 will live part of their childhood in a single-parent household. More than a half million births to teenage mothers occurred in 1989, over 13 percent of all the births in the United States that year (Ahlburg & DeVita, 1992). Adding to this, over 1,400 teenage girls a day become mothers, many of who will seek public assistance and need child care, as well as being required to enter training or education programs while on public assistance.

In the past decade the emergence of new family patterns has had an impact on child care. The changing roles of parents within the family unit and the end of public perceptions of child care as merely baby-sitting have ushered in an era of demand for quality care and increased economic benefits for providers. There has also been a substantive increase in children enrolled in child care outside of their home. A heterogeneous system of settings and services has emerged in response to family need, public policy, funding, and availability of locations.

Parent Choice

Given the varied reasons parents seek child care, the choices these parents make regarding the type of care, the geographic location, and the qualifications of the providers, differ substantially. Choices of child care can also be influenced by economics, age of the child, opportunities available, and length of time the child will be in care. There appears to be a positive corresponding relationship between the mother's education, race, and ethnicity and the number of children in child care (Dawson & Cain, 1990).

Many early childhood programs are now combining enriched learning with extended care as parents work lengthy or irregular hours, requiring extended or flexible child care arrangements. Parents with children with disabilities require staff to be spe-

cially trained in their care, restricting opportunities and choices for child care. Figure 1–2 illustrates the choices families consider in selecting child care.

In 1991, the National Center for Children in Poverty studied issues related to low-income parents as child care consumers and found that low-income parents, especially those on welfare, require additional assistance in choosing care because they may not have access to sources of information that many other parents may use (Mitchell, Cooperstein, & Larner, 1992). Publicly funded child care provides for parent choice, sometimes through vouchers or certificates, or through a subsidy as in the dependent care tax credit. The Family Support Act, the Child Care and

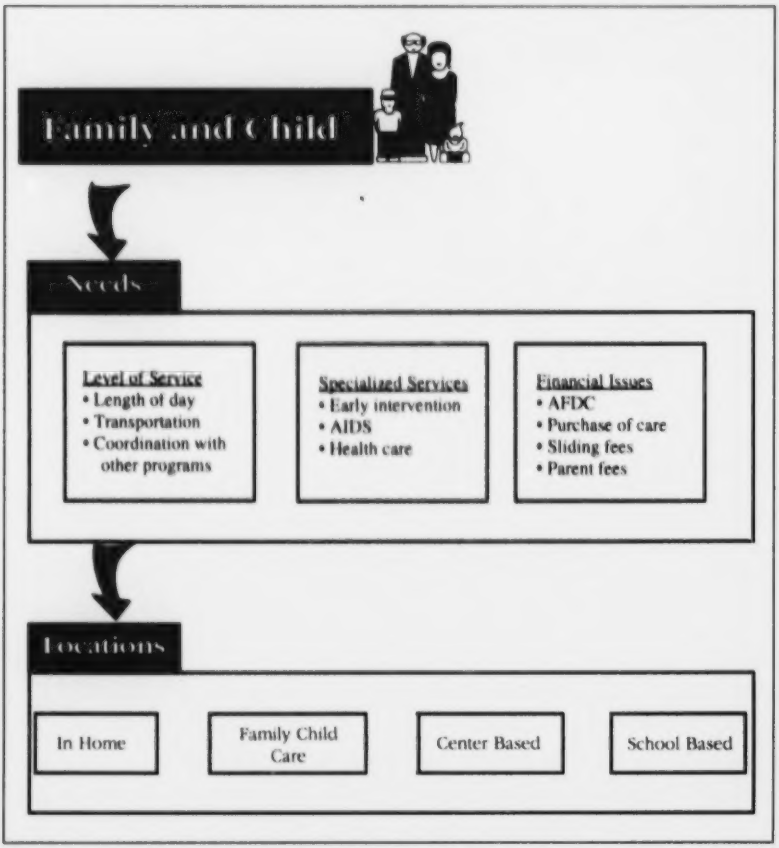

Figure 1–2. Choosing care based on the needs of the family.

Development Block Grant, and the Title IV-A At-Risk Child Care Program promote parent choice in child care through a variety of mechanisms. Table 1–2 provides an overview of the direct public subsidy programs.

Choosing Child Care: Information and Referrals

Child care resource and referral agencies can provide early childhood providers with information about specific state agencies or local providers. Parents seeking specialized child care can contact a variety of organizations and agencies to identify local providers. Chapter 5 more fully describes the role of the child care resource and referral agencies. Appendix A identifies these agencies throughout the United States.

The Child Care Market: Supply and Characteristics

Children receiving care by individuals other than their mothers has increased dramatically over the past decade, both in actual numbers and in array of options. Although the complexity of the child care picture has increased, the most significant surge has been among center-based programs, which have tripled since 1976–1977.

Table 1–2. *Child Care Choices and Public Subsidies*

Federal Program	Target Client	Purposes
Family Support Act (FSA)	•Parents with young children •Receiving Aid to Families with Dependent Children (AFDC) •Participate in Job Opportunities and Basic Skills (JOBS)	•Pays for child care for JOBS participants •Child care assistance for up to one year after leaving AFDC
Child Care And Development Block Grant (CCDBG)	•Provides states with funds to improve quality and availability of child care	•Assists low income parents to pay for child care •Informs parents of state policies on child care •Offers parents information on child care options
Title IV-A At-Risk Child Care Program	•Provides child care assistance to working parents who without it would have to leave their jobs	•Supports parent choice •Permits parent to choose type of care

A Profile of Child Care Settings (Kisker, Hofferth, Phillips, & Farquahar, 1991) funded by the Office of Policy and Planning at the U.S. Department of Education described comprehensively the characteristics of early childhood programs in public and private centers, nursery schools, preschools, and family day care homes. At the beginning of 1990 there were approximately 80,000 center-based early education and child care programs and approximately 118,000 regulated family day care providers, with a total capacity to serve over 5.8 million children. Table 1–3 overviews child care settings.

Center-based care is more available in metropolitan locations, with regulated family day care equally available in both metropolitan and nonmetropolitan areas. The supply of center-based care for infants and toddlers is less available, with fewer than 10 percent of all vacancies able to be filled by infants and toddlers.

The widespread supply of child care offers a full range of programming and financing options for children and families. Two thirds of the center-based programs are nonprofit, sponsored largely by religious organizations, public schools, or Head Start. For-profit programs are operated for the most part by independent entrepreneurs rather than large corporate chains. The majority of home-based programs provide full-time care, with only two thirds of center-based programs providing full-day programming, and only some with evening or weekend options. Additional services provided may include physical examinations (13 percent of center-based) and assessment in the areas of cognitive and social development (40 percent of center-based). Few for-profit programs provide physical examinations and only one third provide developmental assessments.

The average enrollment of center-based programs is 62 children, whereas home-based programs enroll six children on the average. The enrollment in center-based programs ranges from 50 for Head Start to 91 in for-profit programs. Most children are enrolled on a part-time basis in child care. Home-based programs serve more infants and toddlers whereas center-based programs enroll more 3- to 5-year-olds.

A Profile of Child Care Settings (Kisker et al., 1991) also found that only 17 percent of the children enrolled in center-based pro-

Table 1–3. *Overview of Child Care Settings*

Setting	Number of Children	Number of Providers
Regulated Family Child Care	860,000	118,000 providers
Center-Based Programs	5 million +	80,000 centers

grams and only 5 percent of children in home-based settings come from families receiving public assistance. However, the majority of children enrolled in Head Start are from families receiving public assistance. In addition, only 25 percent of center-based and home-based programs adjust their fees based on family income (sliding fees). Eighty-five percent of center-based and nearly all home-based providers charge at least some parents for care. The study found that the average fees charged to parents by center-based and regulated home-based programs, after adjusting for inflation, have not changed much since the late 1970s.

Crisis in Salaries

Turnover of staff in child care, as a result of poor wages, damages every facet of the quality of child care available. Consistency in child care providers influences the ability of children to benefit from the child care experience. Continually changing child care personnel decreases the child's attachment to the provider, resulting in anxiety and fearfulness in a young child. Much of the literature indicates that children in child care do as well on attachment and developmental measures as children with at-home mothers, but if the caregiver is inconsistent, then the ability of the children to form attachments is jeopardized.

With the increased demand in the nineties for all types of child care, many programs find it difficult to recruit and retain qualified personnel in sufficient numbers. Not only does the quality of programming suffer with turnover and high staff-child ratios, but the safety and emotional well-being of children also become issues. Parents need to establish rapport and communication with their care providers so as not to worry about their children's welfare and to ensure consistency between the home and child care setting.

In a comprehensive study of the compensation patterns of agencies providing services to children and their families, the Child Welfare League of America (Curtis, 1991) found that salaries varied across the United States and were highly correlated with staff size and agency income. Salaries usually were higher in statewide programs and local public agencies rather than in private and nonprofit agencies. In addition, the study found that the higher the salaries, the lower the turnover rates. Turnover is also related to supervision, workloads, opportunity for advancement, and training. Figure 1-3 identifies the supports for child care providers.

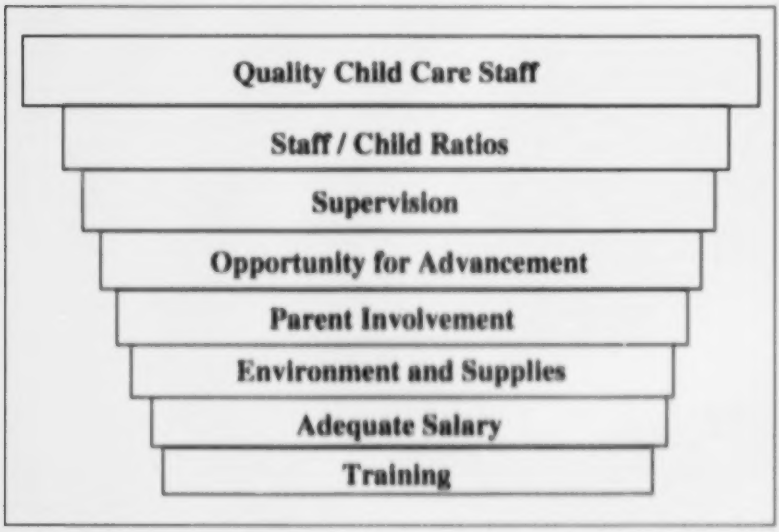

Figure 1–3. Reducing staff turnover.

Since the mid 1970s salaries have declined nearly 25 percent, when adjusted for inflation, despite more education and training. Annual teacher salaries in child care centers average $11,500, while half earn less than $11,000 per year. Among regulated family child care providers, the average annual income is $10,000 per year, with half receiving less than $8,000 per year (Willer, 1992).

Utilizing the Child Care Setting for Learning

The child care setting also can influence the early learning of the young child, ultimately impacting on school performance. Individual children respond differently to their experiences. For example, inborn temperament, prior history, parental interactions, and developmental readiness for a particular environment all influence the child.

School readiness is one of six educational goals for the year 2000 adopted in 1990 by the National Governors' Association and the Bush Administration. The National Association for the Education of Young Children (NAEYC) has endorsed goal one of America 2000, which states that all children will start school ready to learn. To achieve this goal, quality early education and child care needs to be available for all children and to all families that need and choose to use them, focused on individual family and child

needs. Zigler and Gilman (1993) note the irony that as a nation we expect children to enter school ready to learn but fail to provide 5 years of quality child care. Achieving these America 2000 goals requires a major shift in priorities to prepare young children to learn, and it will require those working in child care settings to use a wide variety of developmentally appropriate curricula, materials, and procedures to maximize each child's growth and development and to support the family's role as the "first teacher."

Developmentally Appropriate Curriculum and Materials

The structuring of program goals and activities for young children related to psychomotor, cognitive, and affective development is influenced by one's particular developmental philosophy. Theories of development are many, but they are consistent in the general developmental structures that affect the children's development. In the maturational view, development is seen as the inevitable result of maturation within the individual, with genetics being an integral component of each individual. Instructional programs, provided when the child is ready, are responsible for the specific content and knowledge that an individual learns.

The behavior-environmental approach views the environment as the input process and behavior as the output mechanism. Skilled teachers wait for a desired behavior and then reinforce that behavior. In addition, modeling followed by reinforcement can be used to demonstrate a particular desired behavior, with praise used to reinforce the child.

Theorists conceptualize genetic heritage and the environment as equally significant in shaping development. The genes influence how the child interprets the experiences of the environment. Figure 1–4 illustrates the varied developmentally appropriate models.

Determining which programs are developmentally appropriate has become complex, involving not only early childhood professionals and theorists, but politicians and funding sources. Kostelnik (1992) examined the myths commonly associated with developmentally appropriate programming and found that there were no definitive practices suitable for all children. Figure 1–5 illustrates the many contextual variables that influence the skills a child may acquire. Teachers need to utilize their background and experiences to assist in implementing the "new" developmentally appropriate curriculums and classrooms.

An appropriate developmentally based curriculum should be provided for all young children in child care settings that are

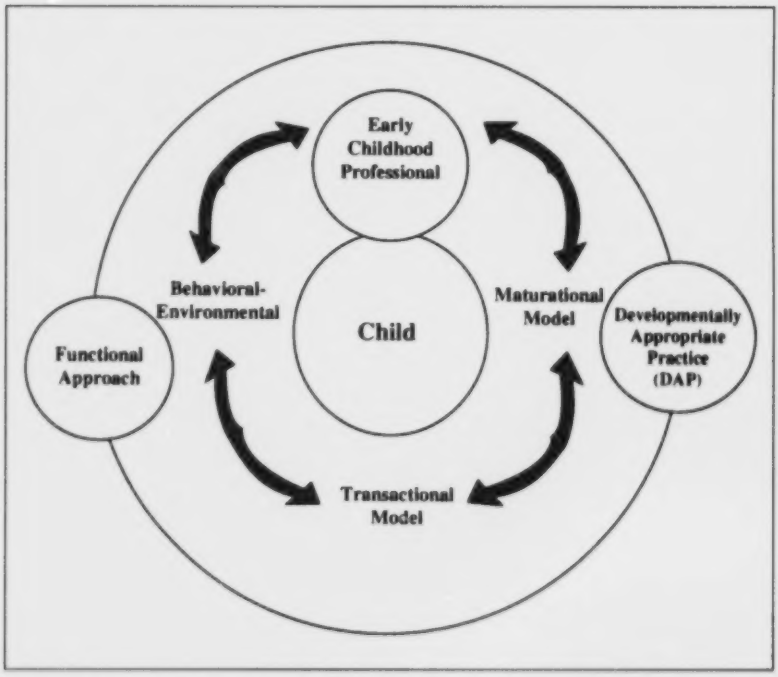

Figure 1–4. Developmentally appropriate practices.

designed to be more than custodial. In larger settings grouping among infants and toddlers can be made according to mobility. As skills are acquired younger children can be placed into older groups. Infants should be assigned to specific staff members to promote sensitivity in caregiving and continuity in programming. Charting of developmental tasks also should include information on each child's feeding and sleeping patterns.

Experiential approaches for young children are frequently the basis for implementing developmental curriculums. Therefore, young children need to be encouraged to explore their environment through discovery of their own creativity and abilities.

Benefits of Early Learning

Child care has progressed from a form of baby-sitting for working or low-income parents to highly developed early educational programming for young children. A study by University of

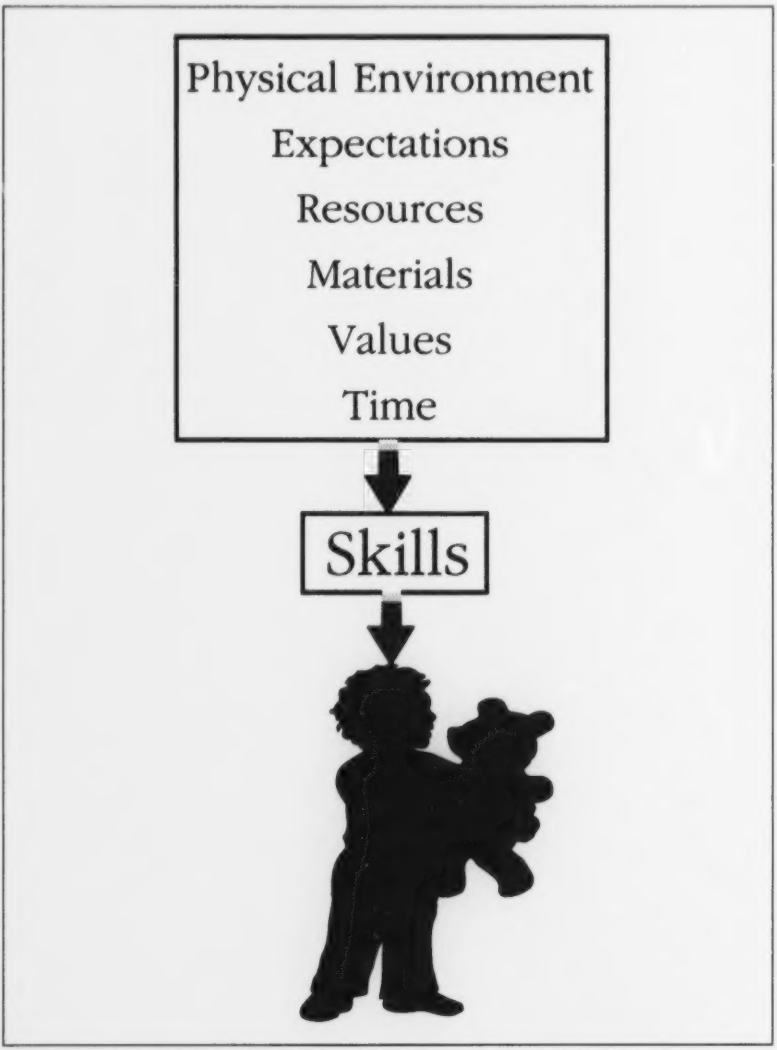

Figure 1–5. Variables influencing the skills of the child.

Alabama researchers found that low-birthweight children who were born prematurely and received comprehensive early intervention services scored an average of 15 points higher on IQ tests at age 4 than the group that received medical treatment

only (Ramey, 1992). The report also found that the most effective programs for at-risk children combined center-based services with in-home interventions to assist parents.

The Foundation for Child Care Research and Education, Inc., found that children enrolled in full-time child care settings showed significant gains in academic and social development, showing advanced skill levels for their age in nature, science, social skills, mathematics, and reading. The approach by the child care centers was to establish activity centers and utilize computers to capture the children's interest. In the centers surveyed the programs had relationships with local community agencies, schools, colleges, and professional groups, as well as strong parental involvement. Researchers found marked improvement in the development of the children that could not be attributed to maturation alone (Durkin, 1991).

Researcher L. J. Schweinhart testifying before the California State Senate Select Committee on Infant and Child Care and Development on October 29, 1987, stated that high-quality preschool programs for children who live in poverty help to prevent school failure, dropouts, juvenile delinquency, and illiteracy, and in the long run, save taxpayers considerably more than they originally cost. Follow-up studies of participants in the Perry Preschool Program at age 19 found that preschool participation had increased the percentage of persons who were literate, employed, and enrolled in postsecondary education, and it had reduced the percentages who were school dropouts, labeled mentally retarded, on welfare, or arrested for delinquent and criminal activity. This effort combined with other early intervention research indicates that high-quality early childhood programs prepare poor children better for the intellectual and social demands of schooling and that participation in early childhood programs can lead to greater success and social responsibility in adult life.

Programs serving young children exist throughout the country. The benefits vary in relation to purpose, systematic research on quality measures, and target population. The complex questions related to the effectiveness of early educational programming increasingly are becoming issues for government and university study.

CONCERNS ABOUT QUALITY

The quality of child care is the most important factor in assessing the care children receive. Quality child care enriches a young

child's life and benefits the family by providing experiences and interactions that are supplemental to those provided within the home setting.

The governmental role in implementing quality child care should be to require licensing or registration to ensure that minimal health and safety standards are met. In addition, government agencies should require specific educational qualifications of child care personnel, as well as criminal record checks.

A Profile of Child Care Settings (Kisker et al., 1991) identified specific characteristics of early childhood education and child care settings associated with quality programming, including group size, child-staff ratios, training, and stability of care. Group size and child-staff ratios have increased since the 1970s, with current numbers in the upper limits of recommended ranges, whereas the average size in home-based settings is in the lower range. Teachers in center-based programs have a higher level of education, and nearly all of these teachers have received training related to child development. Teachers in public school-based programs are more likely than teachers in other programs to have a college degree, whereas only 12 percent of regulated family day care providers have graduated from college and 11 percent have not graduated from high school.

A Profile of Child Care Settings (Kisker et al., 1991) found a relationship between higher quality programming and higher parental fees. Also associated with quality is the data related to teacher turnover, with a 25 percent annual turnover rate in center-based programs, with the highest rate in for-profit chain programs (39 percent) and the lower rate in public school-based programs (14 percent). This may be attributed to the positive effect of the higher level of training for staff in public school programs.

Parental involvement in child care programs has a significant influence on the quality of the young child's experiences. Parents who are more actively involved often have improved communication and a better understanding of child care routines, the quality of the personnel, and the monitoring of the program. Parents can influence the quality of care provided to their children through their level of participation in the daily routines of the program and facility, including volunteering, participation and funding of field trips, donations, and site visitations.

Many parents are limited in their choices of child care. Even with sufficient resources, there are not enough quality care programs available for children. Also, in determining quality care there are two perspectives to be examined. One is to view child care as a service to the child, and the other is to view it as a ser-

vice to parents. High quality care for a child may be too costly or inaccessible for parents. Care that is convenient and not too costly may not feature the services that are important for many children, including health care, supplemental meals, and developmentally appropriate programming. The benchmarks for assessing the quality of care should be staff-child ratios, personnel training, turnover, and developmentally appropriate activities.

Parents are ultimately responsible for protecting their children in care. Initially parents must be aggressive in selecting quality programs that meet not only state standards, but also ones compatible with their needs. The continuing parent role should be to passively influence daily routines through entering the facility at any time, ongoing communication with the provider, and interaction with other parents.

Unregulated Care

Many parents have their children in unregulated care or illegal child care services. *The National Child Care Survey* (Hofferth, Bayfield, Deich, & Holcomb, 1991) has estimated that there may be as many as 3.1 million children in some form of unregulated family child care. States discourage the use of unregulated care since children may be at risk due to neglect, abuse, health and safety violations, and unqualified providers. Unregulated care costs less, offers lower staff salaries, and typically has higher staff turnover.

The use of unregulated care depresses the overall costs of care which is the reason many parents will select this type of care over more costly for-profit and not-for-profit care. Neighborhood care, which is convenient and offers part-time or flexible hours, usually is unregulated also. Many states offer amnesty programs to encourage family child care providers to become registered. Increasingly newspapers will not accept advertisements without verification of licensing.

The use of regulated care at the least ensures adequate training in the development and care of young children. Minimum health and safety codes are enforced, which can mean the difference between the death of children in a fire or adequate safety devices and procedures that can save children's lives. Fingerprint analysis required through licensing in many states can identify providers convicted of child abuse anywhere in the nation. Staff-child ratios are lower in regulated care, with special requirements for infant programs. The use of unregulated care can realize

financial savings for parents in the short run, but at a cost of inappropriate practices, and ultimately, dangerous situations.

Status of States

Investments by states in quality child care and early childhood programs to prepare children for their futures are uneven across the nation. Many states appear not to be fundamentally committed to developing and supporting quality child care, nor do they appear to recognize the needs of their workforce in recruitment and retention of employees. Increasingly states are faced with budget cuts, which undermine efforts to promote quality care that meets minimum safety and health standards. A recent U.S. Government Accounting Office Report (1992), which examined states' efforts in enforcing standards and promoting quality, found that states have reduced on-site monitoring, a key oversight activity that is necessary for the enforcement of standards and ensuring minimum quality care.

Many states supplement the effectiveness of standards by using other nonregulatory methods to improve quality of care, including consumer education programs, training supports for providers, and complaint hotlines. Many legislatures require liability insurance for providers and impose requirements on carriers. Insurance carriers will not insure providers who are unlicensed or do not meet minimum health and safety standards. This discourages the use of unregulated care.

Expenditures for child care remain low in many states. A study by the Children's Defense Fund (1992) ranked Idaho lowest in a survey of states, spending only 24 cents for every child in 1990. Five states spent more than $70 per child in 1990, including Alaska, Connecticut, Massachusetts, New York, and Vermont (Adams & Sandfort, 1992). Ironically states spend more on corrections and prisons than child care for young children, and many states spend more on the elderly in the middle income brackets than on the development and care of young children. Inadequate funding by states for child care reduces the diversity of the available workforce and forces many single parents onto the welfare rolls, rather than into the workforce as taxpayers.

Some states have adopted measures that significantly strengthen resources for working families. For example, Florida passed a children's package that included major initiatives for early childhood education and child care, doubling annual funding for prekindergarten programs. Vermont increased its child care

budget primarily to help subsidize care for children of low-income families. Minnesota increased child care funding to supplement a program that helps low-income families pay for child care costs. Funds also were to be provided to agencies to start or improve resource and referral centers that train child care providers and help parents find adequate child care. Family day care providers and centers were also provided with grants for facility improvement and training. Ohio's legislature voted to increase child care spending targeted to help teenage parents complete high school and to assist parents on Aid to Families with Dependent Children (AFDC) to obtain employment. In addition, Ohio will provide funding to create a new early childhood education program intended to enable more poor children to be served through Head Start.

FINANCING CHILD CARE

Comprehensive child care services for families are not available from a single funding source. Practitioners need to become familiar with the many programs that provide funding for services and frequently coordinate several to meet the varied needs of families. Current systems of financing are insufficient, but in combination with an early intervention program may meet the full day needs of young children.

Federal and State Support: Sources for Child Care

Comprehensive child care programs for infants and toddlers can be supported through a combination of federal resources. Every year millions of families take advantage of tax credits. Families are eligible for an Earned Income Credit of up to $2,211 if they earned up to $22,370 in 1992 and had one or more qualifying children. Families of any income level are eligible for the Child and Dependent Care Credit of up to $1,440 if they had child care expenses for children under the age of 13 in order to work in paid employment. Other federal resources include several programs available under Title IV-A, for example, Child Care for Jobs and Education Training, Transitional Care, At-Risk Child Care, and Child Care Licensing and Monitoring Improvement Grants. The Family Support Act of 1988 made child care funds available to every child eligible for Aid to Families with Dependent Children (AFDC). These funds are part of a larger effort to support AFDC families participating in employment or training. Under Title XX funds, states may provide families with low incomes support for child care.

The Child Care and Development Block Grant (CCDBG) provides states with federal funds to address affordability, accessibility, and quality of care. Under this legislation states must use 75 percent of these block grant funds to help families pay for child care or to improve the quality of child care. Working parents are eligible for funding assistance if their children are younger than age 13 and their family income is less than 75 percent of the state median income. States are required to provide parents with certificates to help pay for the child care of their choice. Parents receiving these certificates may select any licensed, regulated, or registered provider. This can include care by relatives, family child care providers, religious institutions, and schools, as long as these providers otherwise comply with state and local laws and the minimum requirements of the federal legislation. In addition, 25 percent of these CCDBG funds must be targeted to early childhood education and children with special needs. These funds may be allocated through a public hearing process to develop unique approaches to providing child care to infants, toddlers, and their parents within specialized child care settings.

Many state systems of child care are overburdened and underfunded. Under the Title XX funds available to states, funding may be allocated to provide child care but only to low-income families. Under this arrangement the state purchases child care slots from providers for a specific number of children eligible under Title XX. The funds are provided to the child care provider only for the specified period of time the child is to be in child care. States do appropriate additional state general funds in their budgets to provide additional slots to low-income families. Parents in "welfare to work" programs usually have priority access to these state-supported slots.

Middle-income families have few options available for assistance with funding for child care. The concept of group care for children has long been associated with welfare in this country, and public assistance has developed around low-income families. Middle-income families may form cooperative centers or seek care available within the neighborhood or located at the work site.

Employer-Supported Child Care

Increasingly parents are seeking employer-sponsored child care. The number of companies offering child care benefits has nearly tripled in the past several years. About 30 percent of firms surveyed by the Society for Human Resource Management (1992)

said they offered child care assistance in 1992, compared to only 10 percent in 1988. Large companies were more likely to offer some assistance, although not necessarily in the workplace. About 90 percent of the firms identified child care related problems as the cause for absenteeism and lateness.

When this convenience does exist, many parents do not receive financial help in paying for the child care. On-site care for the children of employees, managed by outside firms, provides access to children during the day and reduces employee absenteeism. Some employers do provide some assistance, sponsoring on-site child care centers, referral services for centers, and some financial assistance.

In many families both parents work full time and as a result spend little time with their children in their home. Increasingly, employer benefits that support the family are gaining in importance. Employer-supported child care for children is also viewed as a benefit for businesses seeking competent employees who will remain with their company. Inadequate and unreliable child care arrangements often result in lost wages and business; missed appointments; vulnerable, unhappy children; and distracted employees. Almost half a million mothers lose time from work because of problems with their child care arrangements, and working mothers spend about $11 billion annually on these child care services (Government Accounting Office, 1989).

The U.S. workforce will grow more slowly during this decade than during any period since the Depression. Skilled employees will be more difficult to recruit and retain. Businesses need to work harder to accommodate workers in order to offer competitive benefit packages. Employer-supported child care can help with recruitment, retention, morale, turnover, and their business image.

FRAMEWORK FOR CHANGE

Amid the clamor for change in the United States, new patterns and types of change agents have emerged. Governments and private agencies have joined to increase funding and raise standards. Families are demanding greater availability and increased quality.

Role of Government

Many feel the government should have a more active role in funding and ensuring quality child care programs. The United

States is the only Western country with no comprehensive government policy on child care. Many parents have concerns about their child care arrangements that need to be addressed more globally, rather than with their individual provider. For some families affordability is the main issue, whereas for others it is lack of access to licensed care.

The Politics Of Child Care

Public policy debates have encouraged parents and early childhood professionals to move their issues front and center in the political scene. Political pressure in support of child care comes from all segments of the population, with families of every income bracket and political affiliation seeking fundamental change in policy to address child care problems. Many employers and governments have begun to understand the importance of child care as part of the economic imperative of this country, that is, as parents work, children need care. For businesses to have a reliable work force, child care must be available to all segments of the work force.

Funding alone is not the issue. Parents want quality child care that meets health and safety standards and is available within the community or work place. Many parents are turning to their community schools to provide recreation, adult education, and child care. Local governments must be convinced that access to these public buildings for multiple use purposes is part of a comprehensive solution to child care.

A variety of federal supports as previously mentioned are available to families to defray the burden of child care on all families. With a growing recognition that the middle class is also struggling to meet its child care needs, the federal government provided a child care tax credit for child care expenses. Social Services Block Grants provide funding for low income children. Child care is seen as an important cornerstone in federal and state welfare reform efforts. The Child Care and Development Block Grant provides for child care for all ages, including a variety of options for settings, including before and after school care. In addition, this bill attempts to address standards for care, training, improved salaries, and special targeted populations. Pressure for improved salaries and increased funding have resulted in changes in the way governments at all levels respond to parent pressure and employer needs.

In the last decade the political agenda has shifted. More children need care, and programs need additional trained personnel.

The passage of the Child Care Development Block Grant was only a beginning to improve the availability and quality of child care. As more women assume public office, the recognition of children and families as important workplace issues may merit more sustained interest. With a new generation of working mothers and fathers moving into positions of leadership, innovative solutions to child care may be available soon.

Public-Private Partnerships: Community Based with Community Support

Private agencies and organizations are assuming a greater role in sponsoring child care. The Foundation for Child Care Research and Education found that most center-based child care programs have established ties to community-based agencies, schools, colleges, and professional groups. These relationships increase staff effectiveness and parent involvement in the centers.

Child care in combination with other early childhood programs requires special emphasis in the development of partnerships, particularly in urban settings. The most likely community partnerships are with parents, business, and service-oriented community groups. In the United States, churches and religious organizations are among the largest providers of care. They encourage community partnerships that invest in the well-being of children and encourage the use of volunteers and parents. They also provide veteran fund-raising expertise.

Coordination of programs within the community for young children improves the effectiveness of these programs and assists working families in participating in these opportunities for their children, while in the workforce. Providing comprehensive programming, which includes available targeted programs, depends on site location and available transportation. Head Start (birth to 5), Even Start (birth to 7), Infants and Toddlers (birth to 3), prekindergarten (4), in combination with child care, provide an enriched, wrap-around programming approach that can most efficiently support the family's needs for child care and the child's need for an enriched, developmentally appropriate early childhood experience.

INNOVATIVE APPROACHES

Culturally Sensitive Approaches

Given the diversity of families and the need for care among all socioeconomic levels of society, child care providers need to be

aware of the many ways to improve their cultural sensitivity and knowledge of individual differences. Child care providers have their own strong opinions on how children are supposed to be raised. Cultural tradition and societal mores shape parental attitudes towards toilet training, holding babies, responding to crying, discipline, and the value of early learning. Parents placing their children in child care are seeking supplemental care, not parental caretakers to raise their children. Child care providers faced with conflicting practices can resolve these through better understanding of the issues and exposure to the positive aspects of cultural diversity.

In resolving and managing cultural conflict, compromise through negotiation can result in a better understanding of the aspects of varying cultures. A greater knowledge of cultural experiences can assist child care providers and parents to better understand each other's perspective. Without resolution, parents and caregivers may withdraw from each other or create conflict situations that are damaging to the children (Gonzalez-Mena, 1992). Parents and caregivers are working to bridge cultural barriers and build relationships across values. The community can provide support by eliminating bias in practice and highlighting diversity in languages, dress, race, and culture.

Intergenerational Care

Recently, Generations Together, a research organization based at the University of Pittsburgh, issued a guide on how to improve the supply and quality of child care workers by the use of older adults in the child care setting, particularly highlighting the contributions of older adults because of their previous experiences and their interest in a wide range of employment options.

Older adults may have increased patience with younger children and can offer their lifetime of experience to parents and younger child care workers. Many seniors are less distracted by the pressures of everyday life and provide a stabilizing influence within a sometimes hectic child care setting. Child care providers report that seniors provide reliable care and consistent workplace attendance. For many communities, seniors are a valuable resource in staffing centers with consistent employees and volunteers.

Young children who spend up to 12 hours a day in child care and come from dysfunctional families may be too disruptive for the typical child care center. Senior volunteers in centers can provide the one-to-one attention necessary for a disruptive child or can handle a larger group of children, while the child care provider deals with the disruptive child.

Seniors who are not interested in direct care for children may make toys, handle paperwork, decorate centers, or repair damaged books and materials. Many retired teachers seek a volunteer experience with children and may be able to develop low-cost supplies for centers.

Sick Children

Sick children create special challenges for parents and employers. Even the most understanding employer must handle employee absences equitably. It is frequently the mother who faces the dilemma of caring for sick children, and complex pressures on employers make it difficult to cover sick child absences. On occasion, providers become ill, leaving working mothers with healthy children but no child care.

To accommodate unanticipated illness, local hospitals are opening sick child care wings that accept children with infectious diseases and other illnesses. Some child care centers have isolated settings that accommodate children with illnesses (see Chapter 2). Temporary employment agencies are also beginning to make substitutes available to child care settings.

The Americans with Disabilities Act

The Americans with Disabilities Act (ADA), Public Law 101-336, was signed into law by President Bush on July 26, 1990. ADA contains multiple provisions regarding employment, public accommodations, services, and telecommunications. Title I deals with employment, requiring reasonable accommodations for individuals with disabilities. This section requires that facilities and equipment are readily accessible, including modifying or altering work schedules to better accommodate the disabled. Another feature requires public and privately owned public entities to make their facilities accessible to individuals with disabilities, including children. Buildings must be made barrier-free, if readily achievable, including child care centers. Regulations implementing these accessibility requirements have been issued and some went into effect on January 26 1992. Smaller businesses and facilities have more time to comply. In individual instances there may be questions as to the application of these requirements.

Meeting Special Needs

Families with children with specialized needs may need child care both for integration of services within the most appropriate

setting and to permit the parents to work. Landis (1992) found that mothers with children under the age of 3 with disabilities entered the work force at approximately the same rate as mothers in the general population. Many of these parents worked part-time or irregular shifts, allowing them flexibility to participate in their children's programs and to make medical appointments. These parents would probably require greater flexibility in their child care arrangements, including hours, transportation, and coordination with other programs.

Infants and toddlers with developmental problems or specialized health care needs or children with HIV or AIDS have a difficult time finding early childhood programs that will take them. Child care may provide the most appropriate community-based setting for early intervention programs to address their needs. Young children with developmental delays and specialized health care needs can frequently be provided with a full day of services, including early intervention and child care. These comprehensive programs can provide for educational interventions, therapeutic services, and parental involvement in a developmentally appropriate environment.

Working with the specialized needs of infants and toddlers with developmental problems involves the use of adaptive equipment and materials and individualized programs based on developmentally appropriate curriculums. Specially adapted equipment not only supports motor development but can be designed to stimulate social interaction through the use by more than one child and mixed age groups. Adequate space is an important consideration in the design of play areas (Herbert-Jackson, O'Brien, Porterfield, & Risley, 1977). Selection, convenience, and access to materials can be facilitated through the location of materials and height of shelving.

The influence of the ongoing examination of the efficacy of curricula among early childhood professionals extends to those working with specialized populations, focusing on the use of developmentally appropriate practices (DAP) versus the functional approach (Lowenthal, 1992). Lowenthal argues for the combination of both approaches to most effectively program for young children with developmental disabilities. Developmentally appropriate practices focus on learning experiences that are child initiated and encourage exploration. Children should be provided experiences that allow choices, independence, and encourage the child in his or her natural discovery of the environment. The functional approach, recognizing the difficulty of young children lacking in certain skills, recognizes the needs to improve specific skills that will assist the child in interactions

with the environment. Task analysis becomes the tool through which instruction targets the skills that the child is to achieve.

The child care setting can facilitate the linking of quality services in a community-based location for families. Comprehensive services programs can be implemented through an array of prevention and treatment services within the familiar child care environment. The co-location of staff and varied services from more than one agency can offer children and families the earliest access to comprehensive services in the most appropriate setting.

In designing child care that is developmentally appropriate for all participating infants and toddlers there must be a commitment to individualized quality care. Meeting the diversity of needs of the children and their families within this type of setting depends on parental involvement, nurturing educators and child care staff, and the availability of therapeutic interventions.

THE FUTURE OF CHILD CARE: YEAR 2000

Trends in the 1990s necessitate child care for parents to maintain steady employment. The next decade will bring greater responsibilities for aging parents and the need for flexible choices for child care and employment. Care for family members must become a matter of everyday support for families, not just mothers. Millions of young children and the elderly are informally cared for by relatives and unlicensed caregivers.

By the year 2000 programs will be focused on the needs of the entire family and will need to be more comprehensive, including health, education, and psychosocial services. Babyboomers will be retiring, leaving a less affluent, nonwhite population to support public programs and create policies for the children and the nation. It appears the major population growths will occur in the South and the West, with California, Texas, and Florida absorbing much of the growth.

With fewer workers, the nation will need to provide higher quality programming for children in care. Single-headed households will create enormous pressures for child care as each worker becomes an important part of the workforce. With fewer resources, governments will need to work together to coordinate policy, funding and resources, staff training, access to programs, and eligibility requirements.

Policy makers and program directors, parents and employers must reconceptualize what will benefit the young children of the

twenty-first century. Limited financial resources will force collaborations among agencies, programs, and private providers.

The nation, if it is to take care of its young children, must provide community-based comprehensive services through national standards and quality programs. Funding streams that recognize the whole family must merge education and health services, promoting collaboration and culturally sensitive programming.

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CHAPTER 2

CHILD CARE SETTINGS AND TARGETING CARE FOR QUALITY

CAROL ANN BAGLIN

SELECTING APPROPRIATE QUALITY CHILD CARE

The multiple factors that influence the development of young children in child care revolve around the selection of settings and targeting care to the specific needs of families. In the real world the problem, however, is the availability, affordability, and appropriateness of these child care services and the availability of specialized training for providers.

The challenges of selecting appropriate, quality care for young children necessitate a basic understanding of how to identify the most appropriate child care setting for the family, what to look for in finding quality child care services, and how child care can be funded for each family as part of a comprehensive early childhood program. All of this can be provided in a general child care setting that is most like that available to all children in this age range. For the family that wants or needs targeted child care, the availability of this care is dependent on trained personnel, supports to the child care provider, and information for the family and providers.

TYPES OF CHILD CARE SETTINGS

Families need access to an array of child care services to complement the complex needs of today's society. Child care providers have the capacity to develop a variety of child care settings to facilitate both child development and to meet the needs of families. Public and private funding influences the availability of a variety of settings that create a continuum of services, including in-home, relative care, family care, and center-based care listed in Figure 2–1.

In-Home Care

Self-Care

There is no incantation which will reveal to the parent the age at which a child can remain at home alone. Just the thought conjures up images too daunting to contemplate. Young children do grow up, however, and parents gain some measure of freedom. There are national and state laws that may govern when it is legal to leave a child alone.

Many parents are faced with economic necessity and make these decisions based on their best judgment of their child's maturity and responsibility. The length of time the parent will be out of the home and the time of the day are factors in making judgments about leaving a child in charge of him- or herself and the home.

The child is generally around middle school age when some may begin to request their afternoons after school be self-supervised. It really is the child who should be ready and express an interest in being in the house alone. Of course, the neighborhood should be safe, with access to friends nearby to take over in an emergency. The child should be able to exercise good judgment and routinely obey the household rules. Some children panic easily and should not be left alone. Leaving children alone requires planning. Notes should be left and activities should be outlined for children, taking into account age and appropriateness. Parents should have a phone-in policy and touch base when children arrive home. Teenagers may prefer to make the call within a time range rather than have a parent call them. All children left at home should clearly understand to never tell anyone that their parents are not at home. Typical responses to such questions asked over the phone or at the door should be provided for children. Nutritional snacks should be provided to

discourage junk-food snacking. Use of appliances should be discouraged since children can become easily distracted.

Young children should never be left alone. Parents may think a sleeping child can be left for a few moments, yet many a

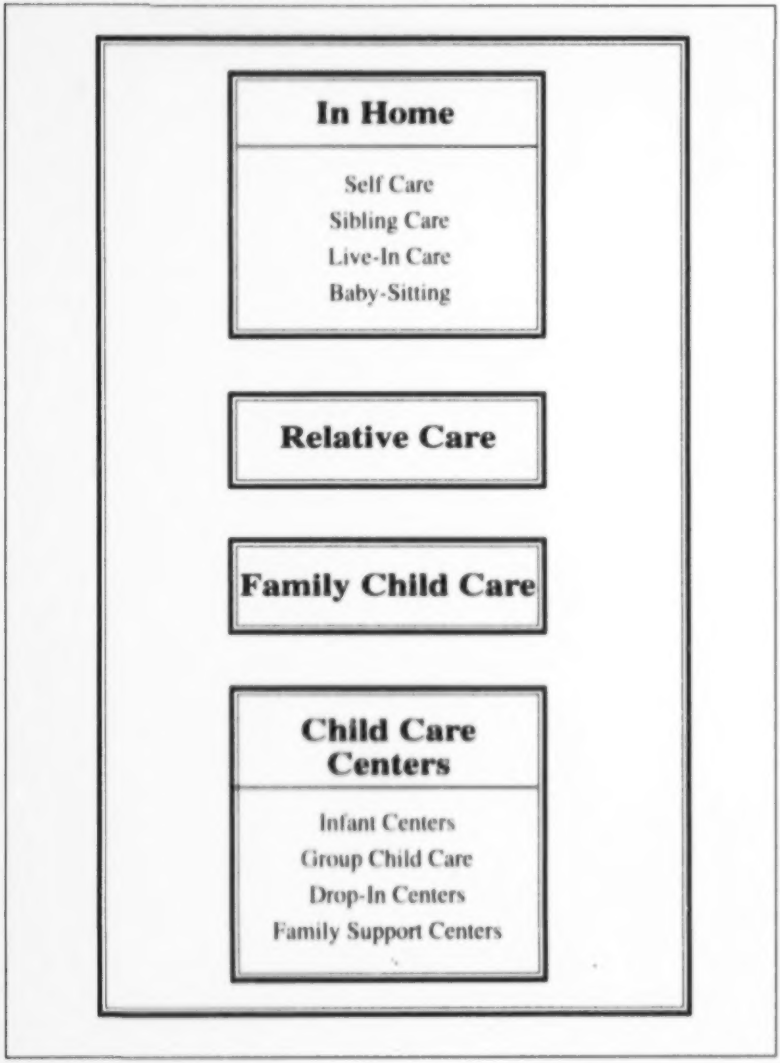

Figure 2–1. Child care settings.

parent has come home to find their house in flames or protective services at the door. Sometimes, young children may appear to be more mature than their years, leading parents to give them more responsibility than appropriate. Young children **cannot** take care of younger siblings, even if parents have to work or have immediate child care needs.

Child care providers are expanding their evening and Saturday hours. In fact, some providers accommodate children for overnight stays. As parent needs change, creative providers can meet the need.

Sibling Care

Some parents, unable to locate or afford appropriate child care, press older siblings into caring for young children. In an emergency parents must utilize what is the most available alternative. Siblings should be trained in the responsibilities of caring for young children and the possible problems that may be encountered within the home setting. In addition, they should know basic emergency procedures such as cardiopulmonary resuscitation (CPR), the Heimlich Maneuver (used to assist someone who is choking and cannot breathe), and when to call 911. Baby-sitting courses or specialized videos for siblings are sometimes available through public libraries or local health departments.

More than 2 million children in the United States are in self-care after school, either home alone or in the care of siblings. In a study to determine the effects of self-care on self-esteem, Berman, Winkleby, Chesterman, and Boyce (1992) studied ethnically diverse children in fourth and sixth grades and found that children who were cared for by older siblings unexpectedly exhibited lower self-competence scores. Children in self-care proved to be more isolated socially than children in adult care. The authors suggest the influence of less parental interactions or financial strains within the family as possible explanations. Children in self-care alone or in care with other adults reported better self-esteem.

Parents need to carefully determine the appropriateness of sibling care for young children and reassess the situation frequently for any negative impact on the young child. Older siblings may resent the responsibilities of care or have other age-appropriate activities that take precedent. Sufficient incentives and flexibility should be an important component of any sibling care arrangement.

Fathers as Caregivers

Sometimes known as house husbands, fathers are increasingly providing care to young children in the family home. The importance of their role in nurturing and supporting children provides an emerging view of caregiving as a fluid family responsibility. Some fathers are more suitable by temperament to care for demanding young children. Many mothers are on a career path and may not be able to divert the course of their work responsibilities. For many fathers, caring for children provides a new opportunity for changing career paths, with ample time for reflection and pause between choices.

Live-In Child Care

For many families with the available financial and home resources, in-home child care is their first choice. Nannies and au pairs are increasingly the choice for care among affluent professionals with busy schedules. Locating a trained professional may be the most challenging phase of the process. Training for nannies is available but some women may apply who are seeking shelter and a job, with few other prerequisites for the job of caring for young children.

Locating Qualified Nannies. In selecting nannies, families usually try a variety of techniques. Some advertise in the newspapers and undertake the time-consuming and sometimes frustrating interview process themselves, trusting their judgment and sensitivity in selecting an appropriate nanny.

Nanny schools prepare young women to provide child care. Potential nannies are provided with child development education, family systems training, safety issues, nutritional information, and how to identify resources when needed. These schools can be contacted to obtain information on referrals and placement procedures. Appendix B provides resources on nanny schools.

Nanny placement agencies generally offer background screening and preselect individuals who are then scheduled for interviews. The quality of the screening process and background check can be uneven, and agencies should be examined for their qualifications, professional affiliations, references, and costs.

Au-Pairs. Another option frequently available overseas and now available in the United States is the au pair, which means

"on par" or equal in French. Usually, young women fluent in English and between 18 and 25 years of age agree to come to the United States and provide child care for a specified period of time. Au pairs are treated as equals and become a member of the host family. The au pair provides up to 45 hours of child care during a five-and-a-half day work week. The au pair will bathe, feed, diaper, and keep the children's areas clean, however, no housekeeping is provided. A private room must be provided to the au pair, as well as meals and a weekly stipend. The initial costs include paying the cost of transportation to the United States, as well as the individual program fees. Screening and background checks are handled through the agencies. Double checking by the host families can be difficult since the au pair is from overseas. Appendix B identifies established agencies handling au pairs in the United States.

In-Home Baby-Sitting

Some families decide that their best option is to have a caregiver come into their home on a daily basis to provide care to one or more children. This is a practical and cost-saving solution for families with more than one child under the age of 5 or with a combination of children requiring full-day care and before and after school care. When young children have serious health problems, in-home care may be the safest and most reliable solution.

Selecting a caregiver to come into the home on a regular basis requires patience and vigilance. It can be difficult to locate the appropriate individual through advertising and interviewing. References are important and should be carefully screened. All requirements should be written down and issues, such as light housekeeping, smoking, phone use, and food, should be thoroughly discussed.

Child care providers seeking to provide care in a family's home need to interview the family regarding **discipline practices, sick leave, holiday periods, social security payments, injury compensation, insurance, and other general expectations.**

Relative Care

In years past it was common practice for families to create informal cooperatives, caring for children on a predictable schedule, thereby allowing shopping, education, socializing, and the necessary routines of life to go on without utilizing formal child care.

In today's world it may be difficult to find a retired and available grandparent, a stay-at-home aunt or sister, or a cousin willing to work hard for low pay and family ties.

Historically, the care of children has been within the responsibilities of the family. Although the availability of relatives to care for young children may be diminishing, these options do exist for families and many indicate this is their preferred choice.

Family Child Care

Many more young children are cared for in family day care settings than in any other type of child care setting. Family child care is typically provided within a caregiver's home and the caregiver's own children are included in the total group. Small family day care homes usually care for 1 to 6 children. Larger family day care homes may care for 7 to 12 children, with adult assistants to meet staff-child ratio requirements.

Care in the home of a nonrelative, typically family child care, is usually state or locally regulated. Minimally, these requirements address zoning, and health and safety standards. In some states, family child care providers must register with the child care licensing agency and are limited as to the number and ages of the children for whom care is provided.

In certain states family child care providers may care for a higher number of infants than usually permitted if appropriate ratios are maintained through infant-toddler assistants. These assistants must meet the same requirements as the family child care provider, including age minimums, medical examinations, criminal record checks and child abuse clearances (where applicable), and certain training requirements.

Licensing Providers

Only a small number of family child care providers are actually licensed, preferring instead to control for themselves the number of children in the home, the amount of money reported to the IRS, and the costs of complying with regulations. Many family child care providers complain that state licensing regulations are actually more appropriate for child care centers rather than the typical family home. Unlicensed care can lead to dangerous safety violations and usually high staff to child ratios.

Developmentally appropriate early childhood education in these settings is less likely, as is ongoing training and support

for the child care provider. Liability insurance is not available to unlicensed child care providers, leaving the provider vulnerable to lawsuits and expensive legal costs in the event of accidents or other risks.

The Costs of Family Child Care

Family child care is usually less expensive than center-based care and offers flexibility in scheduling and smaller group sizes. The home environment and the daily household routines offer a more informal opportunity for children to play with other children their own age and to be cared for in a home-like environment. The age groupings are frequently mixed and sometimes include school-age children for part of the day. The family child care provider needs training and knowledge to have the skills necessary to work with children during multiple developmental stages and to work with varying levels within the same setting.

There are an estimated 1.5 million family child care homes in the United States. The average cost of care is $75 per week. Children under 5 of employed mothers are cared for in their own home 31 percent of the time. This type of care may be unregulated and frequently provided by relatives (Pizzo, 1989).

Substitutes

Family child care providers usually work alone, but must provide for substitutes for illness or emergencies. Without these provisions parents could be faced with critical child care emergencies with few options. Providers need skills in food preparation, fire safety, zoning requirements, equipment needs, and first aid. Since child care is also a business, bookkeeping and some tax accounting knowledge is helpful. Family child care, however, remains largely an invisible enterprise, with small home-based operators.

The Need for Training

Many family child care providers are themselves parents of young children. Frequently, parents seeking family child care mistakenly assume that parental experience ensures a good program and adequate knowledge of early childhood development (National Institute of Mental Health, 1978). However, a caregiver needs to have training in early childhood development, as well as possessing the nurturing qualities necessary in caring for young

children. With infants that have special needs, additional training and support is necessary to ensure an appropriate environment for child care.

Training has become an increasingly available resource for family child care providers. Many states are using their Child Care and Development Block Grant (CCDBG) money to initiate substantial training programs aimed at increasing the pool of family child care providers and promote the professional status of child care. Family child care networks provide support and help to providers, decreasing their sense of isolation and increasing their sense of professionalism. Peer support groups such as local and state family day care associations are available to providers. Workshops include training in early childhood development, use of developmentally appropriate materials, behavior management, home business management, first aid and CPR, parent education and workshops.

Child Care Centers

Child care centers provide care and education for children in a nonresidential setting and are open on a regular basis. Full-day care centers for infants, toddlers, and children are open for 4 hours or more per day. Part-day centers usually enroll children for less than 4 hours per day.

Infant Centers

Any mother returning to work or school following the birth of her child is filled with doubts about who is best able to care for the baby. Unfortunately, she often has few options from which to select.

Center-based care for infants has been increasing in availability in recent years due to economic pressures from many parents. Many employers require that mothers return to work immediately following release from their physicians. Until recently many states had not established regulations for infant center care, particularly when infants had developmental problems or special health care requirements. In the United States only about 7 percent of infants and toddlers are cared for in centers, compared to 21 percent of this age group in France (Richardson & Marx, 1989).

Caring for infants in group settings increases many pressures and demands especially those associated with diapering, feeding problems, sleeping, and dealing with individual infant

temperaments. Centers providing child care for infants and toddlers should have separate areas for changing diapers, sleeping, feeding, and safe play areas. Because, the needs of infants and their families are specialized, programs must be willing to adapt to the uniqueness of each baby.

Visiting the Center. Parents should try to plan to visit a prospective infant center during varied activities, such as mealtime. During this time they can observe whether finger foods are encouraged, the method of bottle feeding, and whether meals are a pleasant experience for the children and adults. Adequate staffing is also important in centers with young children, and staff breaks need to be scheduled around mealtime, ensuring safety and enough adult hands during this process. Sleeping arrangements should include adequate ventilation, safety provisions, and cribs within view allowing for supervision.

Cleanliness of the center is important to monitor carefully. Floors should be covered with carpeting that is easily cleaned and gentle on young skin. Food storage and cleaning of the diaper area are especially important in any center for groups of infants and young children. Creating the appropriate environment through physical layout enhances developmental motor activities and encourages physical movements, including crawling, running, and jumping. Young children need to be encouraged to explore and develop motor competence as this often helps to improve self esteem.

Training. Child care providers who work with infants and toddlers often need additional special training and are the heart of quality programs (Daniel, 1990). This training includes learning to communicate in special ways with some children, as well as understanding the need for structure and the development of a supportive atmosphere. Particularly when providing care to young children with severe handicaps, child care providers need special training in dealing with the unique behaviors of these children, such as responding to visual stimuli and postural orientation toward vocalizing (Rose, Calhoun, & Ladage, 1989).

Developmental Issues. Some researchers have suggested there is an increased risk that infants in out-of-home care are at risk for later developmental disabilities or attachment disorders. Caruso (1990), in a study that examined the quality of interactions, found that mothers whose infants had been in child care from an early

age were not different from mothers of children reared exclusively in the home. He did find, however, that mothers were more sensitive to their children's cues and had more socioemotional growth-fostering behaviors than child care providers. Inherent biological and family issues are the significant factors in later developmental or socioemotional problems.

There is a growing recognition among child care providers that an increasing number of very young single mothers are returning to work soon after childbirth and that low-income women are entering the workforce at a higher rate. Family relationships are readjusting after the birth of a child, and young mothers are facing increasing demands on their time and resources. The father's involvement in the relationship and life of the child can influence the quality of the attachment relationship between the mother and the child.

In a comprehensive analysis of infant care as a child care provider, it is more important to focus on the quality of the child care provided to the infant rather than risks associated with out-of-home care. The care should be responsive and understanding, caring for the infant as a whole being with physical, cognitive, social, and emotional needs.

Group Child Care Centers

Group child care centers provide care to a larger number of children, usually in facilities. The care is not residential but is provided for a major portion of the child's day. The licensing for child care centers may be complex and varies extensively from state to state. Many church-linked child care centers are exempt from licensing, resulting in uneven care.

Child care centers have proliferated in the 1980s and 1990s with parents increasingly choosing centers as their form of child care. Many parents choose centers over other types of care, citing convenience, diversity, and safety among the reasons. Child care centers also can be part of the social network of communities and provide linkages to other services and agencies, particularly in rural or urban settings.

In most of the studies of family and center-based care few differences were observed. Centers generally have a higher level and quality of materials, as well as greater play areas. The training and education level of staff in child care centers is higher and therefore quality conscious parents shop carefully for the appropriate center for their child.

In a recent study Turner, Snow, and Poteat (1993) reported the injury rates of children in day care centers and family day care homes. The overall rate of injury in all facilities that responded was 19.6 per 100 children per year. Of the 66 total injuries, 21.2 percent required medical attention and all occurred in child care centers. More accidents occurred among male children, with the largest number of injuries reported for the 4- and 5-year-olds. Falls from playground equipment or while running were the leading cause of injuries, and most of the injuries were self-inflicted or unintentionally inflicted by playmates. The most hazardous indoor site for injury reported in the study was the classroom, while the playground was the most hazardous outdoor location. The leading types of injuries reported in the study were cuts, abrasions, bruises, and bites. The study concluded that most of the injuries occurring in child care can be prevented through modifications in the environment and through increased supervision by providers, with the emphasis on playground supervision and prevention of running.

Drop-In Centers. Drop-in centers provide temporary child care while parents are in malls, educational training, or other co-located activities. Child development activities are offered only to children whose parents are on-site. It can be a challenging task to provide quality child care in a setting as informal as a drop-in center. Since children served range in ages and since a different number and group of children arrive each day, staff members need to make flexible plans for activities, toys, and snacks.

Because of the inherent lack of predictability of the number and type of children needing care, staff must be trained to deal with the responsibility of unfamiliar children and with potential health or behavior problems. The child care area also provides informal opportunities for parents to see how their children interact with other children. Communication between parents and drop-in staff can be enhanced by general parent information letters, bulletin boards, posted messages, and brochures.

Family Support Centers. Family Support Centers are community-based programs and provide an array of services to families with young children. These centers frequently are located within high-risk communities to assist families that may be affected by adolescent pregnancy, low birthweight babies, poverty, high drop-out rates, child abuse and neglect, drug use, high unemployment, and instability within the community. Child care

is usually provided on a drop-in basis, in addition to other core services. An array of health, education, and social services are provided, in coordination with other agencies, public and private. Although child care is provided, parents are on-site and the service is limited in duration. It provides a valuable adjunct to this neighborhood-based system of family support services.

Because each center is responsive to its community and involves its members as equal partners in program development, each center presents a different array of services. However, at the heart of the Family Support Center philosophy is the idea of service coordination, interdisciplinary teamwork, and viewing the family as a total unit. To that end, each Family Support Center provides core services to include: services designed to enhance parenting skills; infant and child stimulation activities that will maximize child growth and development; outreach services targeted at community organizations, families, youth, and others to ensure community awareness, acceptance, involvement in planning and participation; job preparation and skill development to assist participants to prepare for, secure, and maintain employment, educational services such as Adult Basic Education, GED, and family literacy; assessment services to identify possible developmental delays and interpersonal problems in children or parents; primary and prenatal health care and education, family planning counseling, and other services to aid participants in making educated and responsible choices related to their general and reproductive health care; temporary developmental child care while parents are in the center; and peer support activities, including recreational and social activities.

A parent cannot leave a child at the Family Support Center. Family Support Center programs provide developmentally appropriate temporary developmental child care services while parents are on-site. Child care can be used by parents participating in activities or in need of respite. Although the child care room is staffed with continuous, consistent child care workers there may be times that an overburdened child care worker requires the increased participation of parents. As parents participate in the child care room, the child development staff can observe the parent-child relationship. This is an opportune time to involve the parent in social-play activities with young children as a process of learning. Parents and staff can exchange ideas in implementing a quality program. The service also benefits the children by providing them with a stimulating environment that enhances their social, emotional, physical, language, and cognitive growth.

TARGETING CARE TO MEET A NEED

Child care has been designed to serve the majority of children in need, those with working parents, and parents involved in training or educational pursuit. Today the variety of care and parental need exceeds the available options, although there are many options for families. Figure 2–2 identifies the varied types of care developed in response to parent need and provider capacity.

Before and After School

With the increasing number of mothers in the work force the problem of latchkey children has highlighted the need for the availability of before and after school child care. School age care serves children before or after school hours. Many of these programs are located in child care centers or in schools, with the

Figure 2–2. Targeting care for children.

major portion paid for by the parents. School age programs typically cost between $15 to $45 per week. There is frequently a greater demand than supply, and many states regularly survey the need for this type of care. A variety of federal funding sources make a limited amount of targeted funds available for before and after school care, but availability of space and interested personnel are added issues in developing options for this type of care.

Many of these before and after school programs offer recreational or activity-based programs, with some offering homework centers as a supplemental service. These programs tend to focus on the primary grades and may have part-time schedules, rather than every day programming.

The needs of the older child are met increasingly through a patchwork of services. Many older children are in self-care or participate in after school programs such as clubs, volunteer activities, and peer group gatherings. Books, pamphlets, and homework hotlines are available to older children. Increasingly, public libraries have become de facto care centers responsible for babysitting children, placing a strain on resources and other patrons. Some older children participate in after-school employment.

Student Parents

Many school systems are providing child care programs for students to decrease drop-out rates among teenagers and to provide parent education programs. Fathers frequently are involved to facilitate responsibility and parent bonding. Child Care Development Block Grant funds are expanding these types of options within states. Flexibility among education and child care professionals can support young families, reducing abuse and foster care placements.

Community colleges make child care available for their students and simultaneously provide field placement experiences for students enrolled in their child development programs. The costs of these child care programs are generally less than other community programs and offer developmentally appropriate curriculums. Parent education components enhance the comprehensive nature of these programs and provide enrichment opportunities for the family.

Child Care and the Welfare System

Purchase of care is made available to families qualifying because of income, job training needs, part of a court-ordered plan for

protective services, or a reunification plan for the family. Under the Family Support Act, a federal welfare reform program, families are guaranteed child care while they participate in job training or receive education. Transitional child care benefits also are available once the parent takes a job.

The child care provider identifies certain slots which are then reported to the state. Funding is provided directly to the child care provider at a specified rate.

Intergenerational Care

With a shrinking workforce and few opportunities for older workers, many child care centers are seeking the experience and patience characteristic of older workers. Older workers are more reliable and are a more stable workforce than younger workers who frequently leave due to low pay and the availability of other opportunities. The Bureau of Labor Statistics estimates that the number of Americans age 65 and older working in child care settings outside of the home has increased by 28 percent from 1989 to 1992. Older workers represent only a small segment of the overall child care workforce but represent a trend (Survey for Human Resource Management, 1992).

The changing demographics of the traditional work pool, such as the decline of the number of people in their twenties, makes this partnership a plus for child care centers and for children. Many older workers have considerable experience in child care, having raised their own children, and make dependable and responsible child care workers. The low wages, while a problem for younger workers, supplement the older workers savings and Social Security. Some older women who are widowed who have not worked outside the home, have to go to work for the first time in their lives. Nurturing young children can be a familiar and comfortable work experience for older women.

Children often respond positively to a grandparent figure and benefit from the warmth and connection with this older generation. Older adults can offer physical contact, providing comfort and support to a young child. An older caring adult can assist children to feel good about themselves and promote self-esteem and unconditional acceptance. Children, however, can be exhausting and require high levels of patience. Screening and training of older workers is an important part of any successful intergenerational program.

Older women working in child care are not qualified simply because they have reared their own children. While these may be

complementary qualifications for early childhood providers, this is insufficient as even an entry level skill. Younger staff can benefit through the advice and support of an older and more experienced adult, but effective training can create a staff system rich in diversity and resources for the children.

Accommodations for older employees may be necessary to meet the challenges of effectively utilizing these workers. Hours may need to be shortened as older workers may tire more easily. Sensitively to the feelings of older adults working with younger providers will need to be addressed by supervisors. Training and support to older adults can assist them to make a valuable contribution to children and to the early childhood profession.

Specialized Child Care

A mother with an infant with developmental problems or special health problems has the added problem of finding not only an appropriate facility, but unique caregivers with specialized skills. Some parents are fortunate in that they are able to have their parent or another relative provide child care. Others may be able to secure an in-home care provider such as a nanny or health aide. Many must rely on family day care or infant child care centers.

Because specialized child care is in limited supply, parents must start the search early and rely on a great deal of luck, in many cases, to find just the right provider. It is suggested that parents network with other mothers of infants with specialized needs and consult with local pediatricians for recommendations. Some larger urban settings offer Child Care Resource Directories that identify providers willing to care for children with specialized needs. Most child care experts agree that it is the qualifications of the child care providers and recommendations that are the best predictors of quality programs.

At a minimum, child care programs must provide children with physical safety and protection. These programs also can function as a significant support system and source of basic information about child development for many parents. For the family with a young child with special needs, child care also may be the appropriate setting for early intervention services.

Federal funds support special projects which provide care to disabled young children birth to age 5 years. The goal is to increase both the level and the coordination of services to young disabled children. In addition many young children need full-time child care and educational services. This type of care can

normalize the parents' lives and give them skills for dealing with their children.

Not all children in child care with specialized needs are easily recognized. Caring for children with attention deficit disorders requires recognition by the child care provider of the behavior patterns common among these children. Attention deficit-hyperactivity disorder (ADHD) is a developmental disorder with specific behavior patterns, including distractibility, difficulty waiting for a turn, excessive talking, fidgeting, impulsivity, and problems following directions. Child care providers can provide structured activities and a predictable routine to support these children. Providing choices among a variety of activities can enhance self-esteem and assist the children to operate in a group setting.

Sick Child Care

Every year working parents must face the reality of caring for a sick child, usually more than once. These are unplanned breaks in a normally hectic but predictable routine of care. Young children experience an average of seven illnesses a year, usually upper respiratory and ear infections. All children are exposed at some point to other contagious diseases which require care in an exclusive setting.

When should a parent choose to keep a child home from a center or day care home? Each state has its own rules, but many consider any child with a fever "ill." Depending on the provider, a child with nasal discharge who cannot care for him- or herself, may be required to stay at home. Generally, a child with a fever over 100 degrees, vomiting, diarrhea, strep throat (within the first 24 hours of antibiotics), measles, and chicken pox should be kept at home. Some children who are more susceptible to illness may stay at home as a preventative measure.

Working families implement one or more of a variety of approaches in dealing with the illness of a child. In many cases one parent stays at home with the child. Frequently this is the mother, but parents sometimes alternate this responsibility, depending on employer policies on family illness, available vacation time, sick leave policies, and impact on the work place. Since illness is unexpected, this is the easiest option to implement on short notice. It does, however, have the most negative impact on working parents and employers.

When extended families such as a grandmother, aunt, or sister are available, these family members can be contacted in

an emergency. Friends who do not work outside the home may be willing to provide care on short notice. Families without reasonable sick child care plans may keep an older child home from school. This can create problems for the older child with school work. All states have compulsory school attendance laws, as well as laws regulating the age at which a child may provide supervisory care to another child.

In some locales, private health aides or sick care services are being marketed to care for sick young children and the elderly. These may provide the care needed, but young children may not be as comfortable with an unfamiliar provider in their home. Parents with housekeeping assistance may leave their child with a person normally available within the home, but one not necessarily trained or sensitive to the needs of a sick child.

The most significant problem for child care providers is predicting who will become ill. Because most illnesses are contagious prior to manifesting recognizable symptoms, by the time a child is really ill, additional children in the center or home are exposed and will become ill. To prevent the spread of illnesses, providers and children in child care must practice basic hygiene techniques. Chapter 5 extensively covers the best preventive measures to be used in group settings.

Increasingly child care is expanding to meet the needs of the working parent and the sick child. Centers may be licensed especially to care for a sick child with special accommodations, with specially trained staff. Certain rooms of the child care center will be set aside to isolate children with contagious illnesses. Hospitals are increasingly advertising Sick Child Care as an option. These clinic- or hospital-based centers frequently advertise and request families to visit in advance, bringing information on immunizations and health histories. Staff may include nurses and specially trained health aides providing the adult supervision. Another important aspect includes the administration of medications and monitoring of the child's condition. Access to doctors for medical emergencies is an important backup for sick children.

Therapeutic Nurseries

Young children with unique behavioral and emotional needs are sometimes placed in therapeutic nurseries for specialized care. These programs are characterized by a sensitivity to meeting the young child's emotional as well as developmental needs (Cataldo, 1984). Besides meeting the needs of their children, the staff and

settings of these facilities frequently incorporate a family training component to support the family in their parenting skills. Staff ratios are usually lower between children and staff and must meet state standards in certification and licensing requirements.

Crisis Nursery programs were developed in the early 1970s to provide temporary child care or respite for children at risk of abuse and neglect. In addition to child care, an array of support services were provided to the families and caregivers of these children. In 1986 Congress passed the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act. This Act established federal funding for crisis nursery and respite care demonstration projects across the United States. The federal legislation defines crisis nursery care as temporary care for children who are at risk of abuse and neglect or who have experienced abuse or neglect. Most crisis nursery programs offer free child care for a maximum of 30 days in any year, usually available 24 hours a day. Most programs accept children at any time, day or night, to relieve a potential or existing emergency in the family. Crisis nursery programs primarily serve children whose ages range from birth to 12 years.

Federally funded crisis nursery programs also are required to provide referral to support services. Most crisis nursery programs, regardless of their funding source, provide support services within their own service delivery system. Support services may be provided by crisis nursery programs or by an array of community agencies through informal or formal collaborative agreements. These services may include:

- family counseling;
- individual counseling;
- service coordination (case management);
- parenting classes;
- access to medical services;
- home management training;
- employment training;
- help lines;
- substance abuse prevention counseling; and
- developmental assessments.

Crisis nursery models for each local service area may differ according to the needs of the families within the community. Crisis nursery programs provide both in-home or out-of-home care and utilize existing day care centers, private homes which have been licensed (similar to foster care homes), or emergency

shelter facilities. Other programs may be located in facilities that are specifically designed as crisis nursery.

Respite Care

Respite Care programs emerged in the late 1960s as a result of the deinstitutionalization movement. Respite care became an essential support to families providing home care. In 1986 Congress passed the Temporary Child Care for Children with Disabilities and Crisis Nurseries Act (as amended).

The federal legislation defines respite care as in-home or out-of-home temporary, nonmedical child care for families who have children with disabilities, chronic, or terminal illnesses. Most respite care programs offer services to families on a sliding fee scale with hourly and/or daily rates. Respite care services can range from a few hours of care up to 3 months of care, depending on the needs of the families and the type of respite care program model available in a community. The ages served by respite programs range from infancy to adulthood. Often programs serve a particular disability or illness (e.g., children who have HIV-related conditions, children who are medically fragile, children with mental retardation).

Parents with young children with very specialized physical and health care needs periodically benefit from a break. Respite care provides these brief periods of time for parents to take a family vacation with other family members or merely allow a parent to go shopping for several hours or take care of their own health needs. Respite care may be made available through public agencies, or private agencies may contract with them to provide these services. Usually, sliding fee scales will be based on a family's ability to pay.

Respite care usually is limited to nonmedical temporary child care services for families and caregivers. Respite care services are provided for children with disabilities, chronic or terminal illnesses (including children with HIV-related conditions), and for children who are at risk of or who have experienced child abuse and neglect.

Family benefits include allowing the family to engage in daily activities, thus decreasing their feelings of isolation; providing the family with rest and relaxation; improving the family's ability to cope with daily responsibilities; maintaining the family's stability during crisis situations; helping preserve the family unit by lessening the pressures that might lead to divorce, institutional-

ization, neglect and/or child abuse; and making it possible for individuals with disabilities to establish individual identities and enrich their own growth and development. Some of the support services can include family counseling, family support groups, parent training, service coordination, assistive equipment services, and access to medical services.

Many respite programs offer services through a host family model in which respite care is provided in a surrogate family home similar to a foster care model. This model allows the child with disabilities to be cared for in a setting outside his or her natural home. Host family models allow families to receive extended periods of respite. State regulations regarding fire and safety codes, licensing, and other requirements must be followed. Most host families are trained by the respite program and paid a daily rate of care. Families are charged on sliding fee scale for this service.

The out-of-home respite care program is similar to a Mother's Day Out program in which a particular facility (e.g., day care center, church, community center) offers respite on certain days at certain times. This type of model allows families to take their children to a supervised environment. Facility-based respite models are staffed with trained respite providers, paraprofessionals, or volunteers who are able to care for children with certain disabilities. Families are charged for services based on a sliding fee scale. This model is effective in rural areas.

In the residential respite model, respite services are provided in a residential or nursing center (e.g., group home, state institution, nursing home, hospital) within a community for individuals with disabilities or terminal illnesses who require skilled care services. Respite, in this model, is conducted by professional licensed personnel, usually for periods longer than 24 hours. Payment for respite services is usually a combination of family fees, state funding (i.e., Medicaid or waiver services), and/or private insurance.

In the out-of-home respite house model, a house that is specifically designed for the provision of respite care is available in the community with 24-hour care. Extended respite periods can occur up to 30 days. The respite house model is usually sponsored by a community or state agency and staffed with professional and paraprofessional staff. Families are charged daily rates based on a sliding fee scale. State requirements for food preparation, staff-child ratio, health and safety, and other licensing requirements must be followed.

Parent cooperatives have been developed in communities, especially rural areas, where respite services are limited. In this

type of model, families of children with disabilities and/or chronic illnesses develop an informal association and exchange respite services with each other. This exchange program allows families to receive respite on scheduled dates. In most parent cooperatives fees are not assessed. This model has proved to be effective for families whose children have similar disabilities. Families feel comfortable caring for someone else's child who has a disability or illness similar to their own child's.

Homeless Care

Young children who are homeless are particularly vulnerable to developmental problems and emotional trauma. Many children become homeless and benefit from specialized intensive child care programs. These children are picked up at shelters where they are living with their parents. The parents are able to seek assistance, apply for jobs, and look for housing. At the child care program the children are provided a clean and safe environment with stimulating toys and developmentally appropriate activities.

Resort Care

Parents increasingly plan vacations to relax, to pursue a particular sporting interest, and to entertain their children. The parents are seeking child care and fun for their children in a safe environment. Child care resorts are now available in hotels, cruise ships, beach clubs, and dude ranches. The quality of these programs vary and because of their setting in traditionally non-child-proof environments, supervision and staff training are important factors.

Resort child care makes available activities that are unique to the setting and exciting for children, including swimming, acting, gymnastic equipment, sailing, biking, horseback riding, and puppetry.

In identifying a resort that provides safe and stimulating child care, parents need to obtain information on the qualifications of the child care staff and the nature of the activities available to the children. As with any child care, staff-child ratios should be clarified as well as emergency procedures, discipline practices, and curriculum.

Holiday Care

Whether children are school age or preschool age, there are holiday or vacation periods when parents work and families need care for their children. This type of care, however, is episodic

and time limited and not suited to traditional child care centers or family day care homes. Sometimes only a day here or there needs to be provided, whereas during the summer, several weeks or months are required. Planning and ingenuity can ensure adequate and appropriate care during these periods.

Frequently one parent can plan vacation schedules around a day here or there. Sometimes a family in the neighborhood is able to provide care or share the responsibilities. Many child care centers now offer drop-in care for children of all ages. These centers have activities that are age appropriate and can provide care based on individual need. Children may not be comfortable with unfamiliar arrangements, but providing time for a visit prior to the actual time of child care can acquaint the provider and the child.

Community agencies provide before and after school care regularly. During holiday periods they provide full-day care, sometimes with field trips and other special activities. The YMCA and YWCA often add camps and other school holiday experiences. Community colleges sponsor children's courses in computers, performing arts, and summer enrichment camps. These are usually an excellent option, but can be expensive.

Caregivers may arrange swaps with other providers to allow each to have a week off. These arrangements provide relief to providers and child care for families. The numbers of children may be significantly higher than reasonable for one provider, so parents should be cautious. The child care provider may secure additional assistance during these periods from parent volunteers in exchange for reduced fees or from college students on break.

Parents can advertise at local colleges for assistance during school breaks, which will probably be a big thrill for the young children. College students are usually energetic and focus positive attention on younger children. Local weekly papers can be a good resource for identifying community members interested in baby-sitting.

Temporary child care can be obtained through nanny schools or through sitting services. It is important to screen these services and request references. Agencies provide a variety of training and may supply materials and toys for employees. Referral agencies such as the National Association of Child Care Resource and Referral Agencies (see Chapter 5), maintain lists of referral agencies in many communities throughout the United States. Fees may be required for this service.

Neighbors who are stay-at-home mothers with young children may be available for part of the week, and relatives sometimes can cover the rest. Any arrangements for holidays or summers should

be reliable and planned in advance. Children need consistency and predictability to benefit from any child care arrangement.

EVALUATING CHILD CARE FOR QUALITY

Professionals and parents frequently identify quality as their main concern in the provision of child care for young children. Recent pressures on policy makers to expand the supply of child care and reduce the costs can be at odds with the need to improve the quality of child care.

Child care is best seen as a collaborative undertaking, dependent on the training available, the choice of provider, the family, the regulations and standards of the individual state or community, and the needs of the child. Parents may not immediately recognize the benefits of quality care, necessitating a caring community which understands and invests in assuring quality early childhood experiences for every young child in need of child care. The child care community has available a wide range of provider choices for children and their families, as identified in Figure 2–3.

In a search for the best child care centers in America (Black, 1992), facilities were identified that met the following criteria:

- positive interactions between staff and children;
- age-appropriate curriculum;
- a clean, uncluttered physical environment with accessible play materials;
- clearly outlined health and safety policies;
- well-balanced meals;
- regularly scheduled physical activities;
- appropriate teacher-child ratios, depending on the age of the children, but no less than 1:4 infants and 1:10 preschoolers; and
- stable trained staff.

During the last 15 years increasingly complex research has attempted to define the quality indicators. Group size and specialized training for the care provider have emerged in these studies as significant predictors of positive classroom dynamics and child outcomes (Phillips & Howes, 1987). In studies related to infant care, staff ratio and the understanding, responsiveness, and training of the care provider were more significant (Meadows, 1991).

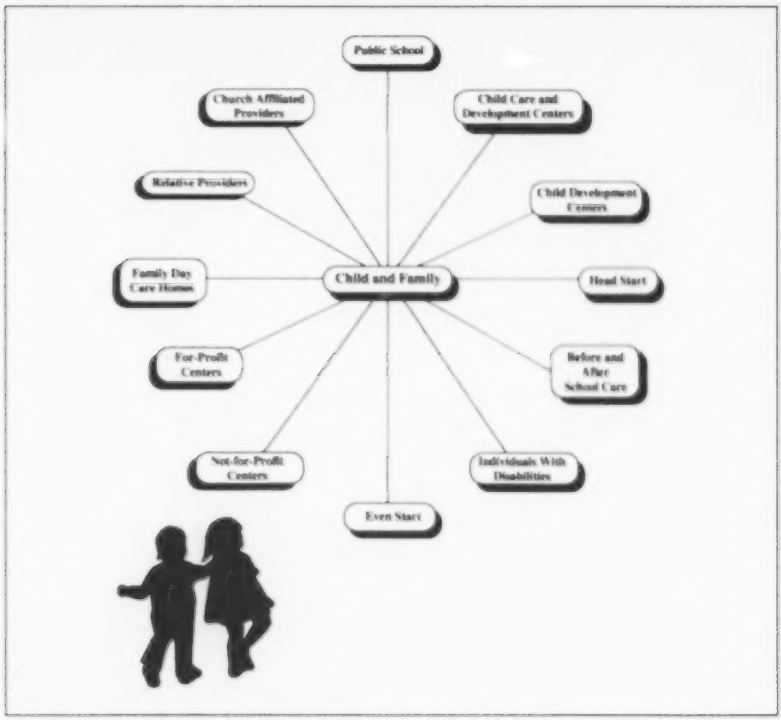

Figure 2–3. Provider choices.

Quality Indicators

Identifying quality programs and quantifying quality for purposes of accountability requires that standards and models be developed. Lilian G. Katz (1992), Director of the ERIC Clearinghouse on Elementary and Early Childhood Education, describes three models or perspectives: top-down, bottom up, and outside-inside.

The top-down perspective examines program and setting characteristics, including ratio of adults to children, group size, quality and quantity of equipment, and so on. The bottom-up criteria depends on how these predictors effect the quality of the experience of the child, such as if the child feels welcome, accepted, enthusiastic, understood, and protected. The outside-inside perspective examines the characteristics of the parent-teacher relationships. The inside perspective includes the three

dimensions of colleague, staff-parent, and relationships with the sponsoring agency.

This combination of quantifiable assessment, combined with high inference variables, provides a comprehensive model for parents, providers, and the community to identify quality care and provides insights for practitioners on improving care.

In 1987 a panel of experts, The Panel on Child Care Policy, was convened by the National Research Council's Committee on Child Development Research and Public Policy to make recommendations on improving child care policies and programs. The panel's findings were published in a report, *Who Cares for America's Children? Child Care Policy for the 1990's*. The goal improving quality in child care focused the findings of this panel around issues such as characteristics, structural aspects, and professional guidelines for quality care (Meadows, 1991).

In an attempt to focus on quality, a criteria for evaluating standards and regulations based on specific indicators of quality was proposed by the panel. The first approach focused on specific structural features of child care, such as group size, child-staff ratios, qualification of staff, and space, similar to the top-down analysis by Katz (1992). The second approach linked the child's development with his or her daily experiences in child care and the interactions between caregivers and children, similar to a combination of the bottom-up and inside-outside perspectives of Katz (1992). The Panel on Child Care Policy found that while structural features support and facilitate desirable interactions, they cannot ensure optimal patters.

The panel makes a distinction between structural and interactive dimensions as a means of approaching the issue of improving child care through government regulations (see Chapter 3) or professional standards (see Chapter 6). Although regulations do establish enforceable minimum standards, professional standards can address both the structural features, quality indicators (listed in Table 2–1), and the interactions between caregivers and children to comprehensively improve quality.

Regulations and Standards

With the demand for child care increasing dramatically, a comprehensive study of child care estimated that in 1990 7.6 million children under 13 years old were enrolled in child care centers and over 4 million were in family day care homes (Willer, et al., 1991). States are increasing regulatory efforts and improving standards to promote quality and safeguard young children.

Table 2–1. *Quality Indicators for Child Care*

Group size
Staff-child ratio
Staff qualifications
Stability and continuity of care
Schedule of daily activities
Developmental curriculum
Space
Regulations
Parent participation

Regulations, licensing, and standards are established for different purposes and may influence the availability and quality of child care, depending on the costs and benefit to providers and families. Regulations are mandatory and are promulgated through a formal governmental process. Licensing standards may be established through local and state entities. Standards are frequently linked to professional organization and national accreditation systems. Ensuring minimum standards that protect children from inappropriate or dangerous child care settings requires a comprehensive approach, including consumer education and on-site monitoring.

The majority of children under the age of 3 are in family child care. Yet most of this care is unregulated, not meeting even minimal health and safety standards. Up to 90 percent of family child care homes are operating outside of the governing regulatory system (Corsini, Wisensale, & Caruso, 1988). Child care centers in the United States do not have to comply with developmentally appropriate or nationally recognized quality standards, and costs may be high, even though child care workers are paid less on the average than parking-lot attendants (Broadwell, 1989).

Without utilizing regulated care some parents may identify excellent resources, however some parents may place their children in a harmful situation. State licensing addresses the need for developmentally appropriate curriculums, qualified child care providers, limits the numbers of children per caregiver, and sets minimum standards for health and safety.

THE ROLE OF THE FAMILY

Many parents want to know they have made the best choice in selecting appropriate child care for their child. Obviously providing for the health and safety of young children should be a priority in

selecting a child care provider. Young children requiring specialized and individualized care frequently need a coordinated program, integrating early intervention services into a setting of quality care. To achieve this parents can be assisted in selecting a child care setting by providing them with the information they need to make knowledgeable choices about a program (Howes, 1986).

A first step parents should make in selecting a quality program is to list all concerns and questions they consider to be important to their family, samples of which are listed in Table 2–2. Next, they should set up appointments to visit the child care homes or centers and observe the staff and the other children. The visit to the home of a provider can convey more information than is available through a phone conversation or through contact with a resource and referral agency. When the visit is made certain issues should be carefully ascertained, particularly through interactive process with the setting. Table 2–3 provides a sample list. It also is important for parent to meet with the staff and ask questions until they understand how the particular center operates in terms of their programmatic and developmental approach to infants, particularly children with specialized needs (Webster, 1990).

Another important step is to call the child care licensing agency in the community and ask whether there have ever been any complaints about the facility or caregiver. Questions to ask include: What was the nature of the complaint? Was there an investigation and what was the outcome? These reports, with the

Table 2–2. *Questions to Ask in Selecting a Quality Child Care Program*

- What communication techniques are used between the child care setting and the parent?
- Is parent access to the facility unlimited?
- What discipline methods, including corporal punishment, are used?
- What health and safety issues (e.g., diapers, communicable disease policy, fire evacuation, emergency plan) are instituted?
- Are foods and medicine refrigerated?
- Who provides the food?
- How are payments, periods of lengthy illness, holiday breaks, and family vacations handled?
- Are substitutes used during periods of absence for teachers and assistants? Will parents be notified of staff changes?
- What is the staff-child ratio?
- How are certifications of teachers and training of support personnel handled?
- What is the availability of the licensing information and reports?

Table 2–3. *Sample of Observations When Visiting a Child Care Provider*

Observe:
Whether the children are content
Staff involvement with the children
Cleanliness of the facility and the children
Use of restraints, such as gates and cribs or tethers
Whether the children are held and cuddled or are in infant seats or playpens
Whether there is a high level of positive interaction and comments by the caregivers for individual children

personalized information deleted, can be reviewed by the public, usually by appointment.

Parents have an important role in monitoring their child care arrangements through adequate visitation, routine inquiries of personnel concerning bruises or unusual physical complaints or problems, and involvement in all aspects of the child care process. Preventive education can equip young children to resist the unwarranted use of authority and intimidation in child care settings. Careful attention by parents in examining child care policies aimed at preventing abuse can reassure parents about the relatively low risk of abuse in child care (Finkelhor, Williams, Burns, & Kalinowski, 1988).

In integrating specialized health care or early intervention services within the child care setting, careful determination must be made that the child care is registered and meets the state's licensing and regulatory standards. This ensures formal training in early childhood development and can eliminate chronic turnover in personnel.

Appendix F lists the major questions that should be asked before enrolling a child in a child care setting. Parents are urged to discuss these questions with parents of children presently enrolled in the program.

Following up on a visit can be done after the parent has had an opportunity to consider what has been observed and to formulate additional questions. Ask if you can talk with other parents with children in the home or center. This can help you better understand the issues you may wish to discuss. Parental access is an important component in evaluating child care. Some states have laws guaranteeing unlimited parental access. Parents are sometimes denied access by well-meaning caregivers concerned that unannounced parents may disturb napping children or disrupt the routines. Parents should insist on unrestricted access to their child and should drop by unannounced to determine the routine practices within the particular child care setting.

Awareness of child abuse and neglect are important issues for parents, providers, and early intervention personnel. The increased utilization of child care by parents requires they be aware of the risk of abuse but not unrealistically cautious in assessing child care programs. Some states, but not all, have mechanisms for tracking individuals who have been convicted of child abuse, *and this prevents their continuing to* work in child care settings. Child Care Licensing and Regulation Offices are required to investigate all allegations within child care settings to substantiate complaints and, when necessary, require the provider to take corrective action. Many states are initiating training programs for child care personnel which ensure an adequate supply of well-trained providers for young children, decreasing the use of unlicensed care.

Improving Quality in Child Care

The current state of child care provides us with the information and expertise to move ahead with meeting the needs of children and their parents. States have the influence to provide incentives to providers to create a comprehensive range of settings and services. Federal support for child care is at its highest level, ever, with funding and resources to establish standards and provide training.

Higher wages should be set to raise the level support for child care providers above the minimum wage, as well as benefits to increase stability and reduce turnover in child care staff. Children need continuity of caregivers, and infants need a consistent caregiver. Full-day programming for children, with consistent providers, is essential for maximum development in all domains.

Training for child care providers should be specific to infant development and family centered care. The National Institute for Early Childhood Professional Development was established by the National Association for the Education of Young Children (Bredekamp, 1992) as an effort to achieve a coordinated professional development system. One of the initial efforts of the National Institute was to identify the diverse systems of professional development regulations, including child care licensing and teacher licensure and certification. The National Institute cites these regulatory systems as a barrier to improving the quality of staff availability in early childhood programs. Other issues identified include the barriers which exist among 1-year, 2-year, and 4-year training institutions; the financial problems with compensation to insure qualified personnel and the need for available scholarships for early childhood education; and the prevailing

attitudinal problems among early childhood professionals, reflecting diverse roles, backgrounds, and disproportionate systems of compensation.

Hiring Well-Qualified Staff

An important component of providing quality child care includes an emphasis on hiring qualified employees who are also sensitive and caring individuals. At a minimum the application process should address questions regarding the applicant's experience with children and documentation of their work history, including a thorough check of references.

The interview process should address specific questions regarding knowledge about child development, parent interactions, children's curriculum and materials, and philosophy of education; attitudes about working with children and overall knowledge of children's typical behavioral and personality characteristics; experience with varied populations and interpersonal skills; program planning skills and special issues such as child abuse prevention and infectious diseases; methods to promote parent involvement; and the long-term professional goals (Bredekamp, 1992).

Prospective applicants also should be observed as they participate in a classroom. Of particular importance are interpersonal skills and interactions with the children and other staff. Any new-hire should be closely observed initially and frequently asked for feedback as to their needs and potential issues for additional training (Allen & Catron, 1990).

TRENDS IN CHILD CARE: MEETING FUTURE NEEDS

As the year 2000 approaches child care has emerged as not only an important economic force but an opportunity for early childhood education and parent education. Child care and early childhood education are becoming increasingly merged for young children, creating stimulating and enriching environments for children and their families. Parent education programs are being provided for the benefit of the children to improve the consistency between child care and home environments. Family centered care will be the priority of federal and state initiatives, with a community-based focus. Family relationships are increasingly diverse and life styles increase the options needed for child care. The future is more positive because of the political popularity of child care and the federal funding available.

However, cutting costs for child care is becoming a priority for families and providers. Parents are pressuring employers to establish dependent care spending accounts which allow pretax salary dollars for care, saving federal income tax dollars. The child care credit allows families to claim income-tax credits on returns, saving 20 to 30 percent of child care expenses.

Young children, particularly those with special needs, increasingly receive early intervention services within child care settings (See Chapter 7). In a survey of parents, child care providers, and early intervention personnel, respondents indicated that care was most frequently provided at schools, child care centers, and in the family's homes. The majority of care is provided for a full day, paid for by parents, and is licensed. Many of the children have special accommodations, including the use of sign language, special diets, health aides, nursing supports, and training. Many of these young children participate in other day programs, including Head Start, prekindergarten, early intervention services, while their parents are involved in adult education programs. Communication with parents is usually through telephone, newsletter, parent meetings, daily child logs, mailings, and informal conversation at pick-up and drop-off. Some parents reported restricted access to the child care setting, which usually is not consistent with state regulations.

Specialized child care for infants and young children with special needs will increase the need for training and standards which support caregivers. Reduced child-staff ratios will be needed, as well as funding for improved settings.

Liability insurance limits the innovative options available to the entrepreneur. Insurance for centers is difficult to afford and places restrictions on providers, creating a crisis in accessibility and affordability. Adequate training for personnel and access by parents, can reduce the risk for child care providers.

Diversity in setting, multiple funding streams, and innovative approaches enhance the future of child care. High-quality care that is affordable will continue to be the reality parents seek. The possibility can emerge from the current climate.

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CHAPTER 3

THE ROLE OF LICENSING IN ENSURING QUALITY CHILD CARE

ROBERTA M. WARD

WHAT IS LICENSING?

Black's Law Dictionary defines a license as a permit granted by an appropriate governmental body to a person or corporation to pursue some occupation or to carry on some business subject to regulation under the police power. A license allows someone to perform an act which otherwise would be illegal under the law.

Licensing of facilities for children in the United States dates back to the mid-19th century in Massachusetts, when concern for homeless children led to the creation of a board to inspect and report on child care facilities (Morgan, 1973). By 1935, child care licensing had been implemented across the country. Child care licensing authority is operationally located primarily in state departments of social services and health departments. In 1990, 38 states placed child care licensing authority in a social services department, 8 in health departments, 6 in umbrella agencies covering health and social services, and 1 in a consumer and regulatory affairs department (Kusserow, 1990).

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Child day care licensing agencies are mandated by state laws to protect children in out-of-home settings by promulgating regulations for the care of children in those settings; inspecting and monitoring child care facilities for compliance with the duly promulgated regulations; and, finally, taking administrative enforcement actions against those facilities which fail substantially to comply with the regulations and laws. While licensing is not a guarantor of quality child care or even of children's safety, it does attempt to create conditions which child care experts and professionals consider basic to the adequate care of children. It also serves to safeguard consumers by reducing the risks inherent when children are cared for by surrogate caregivers rather than parents.

State Licensing

State licensing schemes or designs for child day care encompass at least two and sometimes three basic types of facilities. First is the family day care home where one caregiver supervises a small number of children in a home setting. The second type of child day care regulated by licensing is the child care center. A center is a more institutional facility operated by a public or private nonprofit or for-profit corporation, person, or other entity which cares for a large group of children, generally from 12 or more up to several hundred. The licensing standards for child care centers are considerably more detailed and rigorous than for the more informal family day care home. In-between these two types of facilities, some states regulate small group centers, which are often larger home-based settings, allowing up to 12 children and subject to more regulations than a family day care home.

Some child care regulatory systems distinguish between licensing of a facility and registration. Registration generally refers to a lower level of regulatory scrutiny applied to family day care homes and may imply self-certification or self-evaluation by the caregiver or provider. However, states are inconsistent in the use of the term registration which sometimes is synonymous with licensing. Licensing is accompanied by greater state oversight and a more formal application and monitoring process than registration, including a regular routine of agency inspections and license renewals.

Licensing: A Property Right

The legal significance of a license or registration is that once issued, it becomes a property right. To deprive someone of a

property right under the United States Constitution requires due process of law. Due process of law means the opportunity for a hearing to defend oneself against charges leveled by the state, in the process of revoking, suspending, or denying the renewal of a license or imposing any lesser sanctions. Because a license is a property right, a government agency must exert considerable legal efforts to take an action which adversely impacts on licensees, such as closing a substandard facility.

Licensing Systems

The components of any state (or local) child care licensing system include (a) rules establishing which facilities are covered, (b) the formulation of regulations, (c) the monitoring of facilities for compliance with regulations by an inspection process, (d) and an enforcement process for taking adverse actions against caregivers whose regulatory compliance history is poor or who otherwise present risks to children (see Table 3–1). Although this chapter uses the term "state child care licensing," there are some areas of the country where child care licensing is a county or city function. The principles of county regulation do not differ from state licensing.

STATE REGULATION OF CHILD CARE

Although licensing is not a guarantor of quality, licensing is a form of quality control. The role of licensing is to ensure compliance with regulations in order to reduce risks and thereby to safeguard children in child care. The intent of licensing is to provide a floor of protection by formulating rules with the purpose of preventing accidents, injuries, or harm to children.

Diversity of State Standards

If a child is a child is a child, then shouldn't child day care standards be uniform nationwide? In the United States there are no national standards to guide the provision of child care. In reality, child care regulation in the United States is a patchwork of varying levels of state licensing authority. Each state under its police powers has seen fit to promulgate its own child care statutory provisions and regulations. These provisions are not only remarkable in their diversity and inconsistent in approaching the problem of protecting children in out-of-home settings, they

Table 3–1. *Evaluating the Components of a State Child Care Licensing System*

COMPONENT	ISSUES	FACTS
Coverage	• Church-operated and public-operated day care often exempt • Family day care with 5 or fewer children exempted by half the states*	• 1 in 6 children are in U.S. child care centers not requiring state licensure* • Over 2 million preschool children are in unregulated family day care homes**
Regulations	• Environmental, health, staffing, child protection, programming are key areas • Child-staff ratio, group size, caregiver trainer have most impact on quality	• Only 10 states mandate child-staff ratios consistent with levels recommended by national child care organizations* • 19 states allow a single caregiver to care for 5 or more infants*
Monitoring	• Frequency of inspections best way to ensure compliance with regulations • Inspector caseloads must be manageable • Unannounced inspections critical to effective monitoring	• Inspector caseloads are almost double the recommended workload** • Nationwide fewer than half of all regulated family day care homes were inspected in a 1988** • Several states have abolished prelicensing inspections
Enforcement	• States have a variety of actions for dealing with noncompliant facilities • Failure to enforce standards results in harm to children, legal liability to state, damage to reputation of regulated caregivers	• States report legal sanctions are difficult to enforce and are time-consuming • Prosecution of illegal providers is a low priority of local law enforcement • Only 347 regulated facilities were closed in 21 states polled in 1988**

*Data from Adams, 1990. **data from Kisserow, 1990.

are also constantly changing in response to political pressures, as well as budgetary constraints. The United States, as a whole, has what may be called a laissez-faire policy toward child care.

What is Covered and What is Not Covered

Perhaps most startling of all in the variations among state licensing systems is what facilities are exempted by state

statutes from licensing. According to a study by the Children's Defense Fund (Adams, 1990), 22 states completely exempt family day care homes serving five or fewer unrelated children from regulation. Altogether, 36 states exempt programs serving three or fewer children. What this means is that the youngest and most vulnerable children, infants and toddlers, who are more likely to be cared for in family day care homes, are unprotected by state regulation.

An unintended consequence of this particular exemption is that enforcement of family day care licensing laws is made difficult, if not virtually impossible. A case example is the State of Virginia. In Virginia, a family day care home provider is not required to be licensed by the state unless he or she cares for more than five unrelated children full-time. However, until recently, this did not include up to five children coming before and after school or the provider's own children or those of relatives. In practice, according to a series of articles in the *Virginian-Pilot and Ledger-Star* in September, 1992, state inspectors juggle the numbers. The article detailed a case example where an illegal home provider, with large numbers of children, was required to reduce the number of children down to the legal limit of five. Subsequently, no action was taken by the state against the provider, since the home had less than the number of children which would require licensing. Shortly thereafter, the provider increased the number of children again, well above the limit (Tennant, 1992; Weaver, 1992). Studies estimate that approximately 75 percent of all children in family day care homes in the United States are in homes not regulated by the states (or localities) (Adams, 1990).

Another common exemption from regulation in effect in many states is the exemption for child care centers operated by religious organizations, the so-called religious exemption. One-third of child care centers nationwide may be operated by religious institutions, yet 14 states exempt these institutions from child care regulations either fully or partially (Adams, 1990). The four states that allow child care centers operated by religious institutions to be fully exempt from state licensing, unless they choose to be regulated, are Alabama, Florida, Missouri, and South Dakota.

A third popular category of exemption from child care regulatory schemes includes programs operated by public schools and other public agencies, such as departments of recreation. Thirty states exempt child care programs operated by public schools from licensing (Adams, 1990). The significance of the lack of coverage by licensing laws of a large number of child care

settings in the United States is that quality suffers. Research suggests that unregulated care is, on average, of poorer quality than regulated care (Adams, 1990). Unregulated care settings may, in fact, represent significant hazards to children. For example, persons with serious criminal drug histories and abuse histories were found operating unregulated, but lawful child care facilities in Virginia while the State was helpless to close them down (Tennant, 1992; William, 1992).

State Standard Setting

No less diverse than the coverage of state licensing statutes are the child care regulations in effect in the 50 states and the District of Columbia. Why the standards for child care vary so widely from state to state is a function of history, politics, and budget. Historically, some states, such as Maryland and Massachusetts, have taken leadership roles in developing child care standards, while other states for a variety of reasons have lagged behind. Politically, the atmosphere in certain states is hostile to a regulatory environment.

In some of the more conservative states of the South and Midwest, a philosophy of rugged individualism persists. Individual rights predominate over the protection of consumers' interests in areas such as child care. The influence of powerful institutions, such as churches, have hindered the development of comprehensive schemes of day care regulation in some areas. State budgetary constraints sometimes put a break on ambitious child care regulatory designs which would cost taxpayers money in terms of hours required by inspectors to monitor and ensure compliance with lists of detailed regulations. Finally, there is a perception by some that tightening state regulatory requirements would price child care beyond the budgets of many citizens.

Whereas rules may differ widely, the process of rule promulgation is generally similar. State Administrative Procedures Acts mandate a public process for regulation development. The modern trend appears to favor the creation of child care advisory bodies, consisting of child care providers and their advocates, with some representatives of state agencies with an interest in child care issues, such as health departments and departments of the environment, as well as the licensing agency and one or two consumers. These advisory committees often draft, review, and revise state child care regulations in concert with the agency responsible for child care licensing.

State legislative committees oversee agency regulations, which are formally published in a state register for public comment and possibly subjected to a hearing before finalization. State regulatory schemes are in an almost perpetual process of revision and review. Some of these revisions are mandated by statutes or procedures. Others appear to be prompted by political pressures or media coverage of tragic incidents of child death, abuse, or neglect in day care settings.

Environmental Standards

All child care licensing regulations break down into several discrete categories. The primary categories are physical plant or environment, staffing, health, program, and child protection. Regulations covering environmental hazards and the building or physical plant of the facility typically require compliance with local building and fire safety codes. They may encompass such issues as lead paint or asbestos and almost always discuss general building cleanliness, kitchens, and the availability of sanitary facilities.

Staffing Standards

Staffing regulations are some of the most critical in day care, as studies show that staff qualifications and staff-to-child ratios are the primary determinants of quality for children in out-of-home settings (McCartney, Scarr, Phillips, Grajek, & Schwarz, 1982; Vandell & Powers, 1983). Training in areas such as child development and early childhood education increases the likelihood of appropriate interactions between caregivers and children.

Although many states recognize the critical relationship between quality child care and caregiver training, some do not. According to the Children's Defense Fund study (Adams, 1990), 34 States require no in-service or pre-service training for caregivers in family day care homes. Only 19 states require specified levels of pre-service training for teachers in child care centers (Adams, 1990). However, a trend toward increasing state recognition of the importance of this area is emerging and more states are instituting requirements for a certain number of hours of formal training in early childhood education before a person qualifies to work in a child care center. Preparation and training requirements are also increasingly being applied to family day care homes.

There is probably no area in child care regulation which receives so much attention as the issue of staff-to-child ratios. These ratios have a major impact on how adults and children interact, how children learn, and on caregiver stress levels. State standards for these critical ratios vary widely. The age range of children most in need of close supervision are the very young, and infants and toddlers. The needs of these children stem not only from the importance of their emotionally bonding with an adult, and having enough adults available to feed, diaper, and stimulate them, but from their total vulnerability and dependency. There must be enough arms and legs to safely evacuate very young nonambulatory children in case of a fire or other emergency.

In a family day care home, generally one adult is left alone to cope with numbers of children in an emergency as well as on a day-to-day supervision basis. The National Life Safety Code, which governs fire safety standards nationwide, recommends no more than 2 children under the age of 2 in a family day care home. Yet, 35 states allow three or more infants younger than two to be cared for by a single family day caregiver. Thirteen states allow five or more infants younger than 2 to be cared for by a single provider. Mississippi allows nine infants between the ages of 1 and 2 or five infants younger than 1 to be cared for by one family day care provider (Adams, 1990). Because many states which regulate family day care exempt the provider's own children in calculating the total number of children permitted in the day care setting, one home provider may actually be caring for upwards of 12 children of varying ages at one time.

For child care centers, the National Association for the Education of Young Children (NAEYC) recommends no more than 3 or 4 infants to one caregiver, 4 or 5 toddlers, or 10 preschool age children. In fact, 19 states allow a single caregiver in a child care center to care for 5 or more infants age 6 months. Georgia and North Carolina allow 7 infants, South Carolina allows 8 infants, and Idaho allows up to 12 infants per caregiver. The state of Georgia allows 18 4-year-olds per center staff member; Alabama, Florida, North Carolina, South Carolina, and Texas allow 20 preschool children per staff member (Adams, 1990).

Health Standards

Another major area of regulation under state standards is health. The most important rules in health regulation are the

requirements that children have immunizations according to recommended schedules and that appropriate sanitary procedures be used in diapering, so as to prevent the spread of infectious diseases. Day care settings are breeding grounds for communicable illnesses, as young children are daily placed in close proximity in confined spaces for prolonged periods of time.

The immunization requirement is particularly significant because of the recent resurgence in the United States of measles and other childhood diseases, such as mumps and whooping cough, because of inadequate immunization. In spite of the importance of immunization, 13 states do not require children in family day care homes to have immunizations appropriate to their age for polio, measles, diptheria-pertussis-tetanus, and mumps (Adams, 1990).

Regulations requiring sanitary diapering procedures are also critical. Infants and toddlers in groups are at greater risk for infectious diseases because they have built up less immunity. Because so many illnesses are spread by the oral-fecal route, diaper changing is, in fact, the riskiest procedure with respect to disease transmission in day care (Taylor & Taylor, 1989).

Program Standards

Program regulations address the types of activities necessary for the healthy growth and development of children according to commonly accepted child development principles. State regulations for child care centers mandate, for example, the inclusion in the daily program of opportunities for individual and group participation, balances between self-selected and staff-directed activities, and active and quiet periods. In addition, a regular period of daily outdoor play is a typical state requirement. Standards that equipment and materials be age-appropriate; safe; nontoxic; and free from hazards such as lead paint, sharp edges, protruding nails, and so on are common (Code of Maryland Regulations 07.04.02.34 and .40, 1991). The amount of regulation the state prescribes for programming in child care centers is related to a state's philosophy regarding regulation and the content of early childhood programs. Generally, requirements for activities, program, and materials in family day care homes are considerably less detailed than for child care centers.

Child Protection

Regulations that impact directly on child protection include requirements for parental access, mandatory reporting of child

abuse and neglect, and recordkeeping, as well as prohibitions against the use of corporal discipline.

Many child abuse experts view unlimited parental access to the child care setting as critical to child protection. Parents need to be able to drop in unannounced and observe their children in the areas where child care is being delivered during the facility's hours of operation. The theory is that such access deters undesirable behaviors on the part of caregivers. Although not all states currently have such provisions in their regulations, recently enacted federal child care legislation mandates that states apply requirements for parental access as a prerequisite to the receipt of federal child care funds by providers (45 Code of Federal Regulation §98.31).

A recurrent issue concerning child protection and licensing is the role of licensing in preventing child abuse in day care, particularly sexual child abuse. Many parents of children who have been sexually abused in day care question the effectiveness of licensing in preventing surreptitious activities. There have been sufficient widely publicized cases of child abuse in day care to arouse a high level of public concern around this topic. A study of sexual abuse in day care by David Finkelhor (Finkelhor & Williams,1988) from the Family Research Laboratory of the University of New Hampshire, concluded that nationally 5.5 children are sexually abused per 10,000 enrolled in day care centers. While this incidence rate may be somewhat lower than the incidence of children abused in private households, it is high enough to raise concern about the protection of children in group settings.

The licensing response to child abuse is primarily the deterrence provided by background checking of caregivers. State laws requiring criminal record checks for persons operating regulated family day care homes and members of their households or employed at child care centers, help to screen out individuals with previous criminal histories of child abuse from working in child care settings. In addition, many state child care regulations contain provisions for checking state child abuse registries. Unfortunately, there is seldom any communication of child abuse information across state lines, and states which do not include a Federal Bureau of Investigation national record check in their procedures will not learn of crimes committed in other states.

The state of New Jersey has gone even further in its regulations in preventing child abuse in day care by promulgating special requirements. For example, in a newly constructed child

care facility, New Jersey requires monitoring equipment (such as intercoms, glass panels, and/or two-way mirrors) to ensure maximum visibility and/or audibility in all classrooms (New Jersey Annotated Code 10:122-5.3).

Monitoring

No matter how good a state's child day care regulations are, they are of little value if the state does not enforce them. Monitoring efforts by states of regulated child care facilities vary widely. In February, 1990, Richard P. Kusserow, Inspector General of the United States Department of Health and Human Services, issued a report entitled "Enforcing Child Care Regulations." In compiling the report, the Inspector General's Office interviewed child care licensing administrators and inspectors in all 50 states, the District of Columbia, and New York City. The consensus of those interviews was that frequent visits are the best way to ensure compliance by regulated facilities with state regulations. However, state licensing inspectors reported that they faced obstacles to conducting such frequent inspections.

Fifteen states inspect only a sample of family day care homes each year ranging from 10 to 50 percent of the total. Inspectors in seven states visit family day care homes only in response to complaints. Some states, in fact, use a self-certification method of regulating family day care, meaning that the provider is expected to self-evaluate compliance with regulations, and no state inspector makes an on-sight visit unless there is a complaint. The report estimated that nationwide, fewer than half of all licensed or registered family day care homes were inspected in 1988 (Kusserow, 1990).

A major obstacle faced by inspectors to frequent monitoring is caseload size. Based on the time study data provided by one state administrator, the Inspector General's Office concluded that average caseloads for inspectors inspecting child care centers nationwide is almost twice the recommended workload, while the average family day care home caseload nationwide was nearly one and one-half times the recommended workload (Kusserow, 1990).

Reports indicate that in a period of economic recession and budgetary constraints, the frequency of state monitoring is being cut back across the country. For example, the state of Minnesota in 1991 pared down the number of inspection items on its day care inspection list from 300 to 19 and went from a full inspec-

tion of licensed facilities every year to one every 3 years. In January, 1992, New York eliminated pre-operating inspections for both licensed child care centers and family day care homes. The New York law instead now requires random inspections of 20 percent of day care facilities after licensing.

There are a few basic ingredients of a good state monitoring system. First, there must be an adequate number of trained inspectors. Inspectors should be trained to apply state regulations consistently and with knowledge of the underlying intent of the regulation. Second, visits should preferably be unannounced rather than announced. A surprise visit gives an inspector a much more realistic view of the actual working of a day care facility than a pre-arranged visit. Furthermore, visits should be as frequent as possible, meaning optimally more than once a year, as staff turnover in child care centers is frequent. Finally, states must be able to respond timely, and sometimes immediately, to serious complaints, including anonymous complaints. In spite of this, the Children's Defense Fund study found that eight states do not respond to all complaints they receive and that five respond differently to complaints that are anonymous. Some states do not respond to all complaints with an actual on-sight visit to the facility, limiting responses to letters or telephone calls (Adams, 1990).

Enforcement

Enforcement means the process of applying sanctions to facilities found to be seriously out of compliance with state regulatory requirements or to facilities operating in violation of state law. There are a variety of sanctions the state may apply. Such sanctions include a range of progressive discipline starting with intermediate sanctions, which include bans on admission, reducing the numbers of children who may be in care, entering into compliance agreements with facilities, conducting frequent unannounced monitoring, and issuance of provisional or probationary licenses rather than full licenses.

Many states also have fining authority over facilities that violate regulations. The ultimate sanctions for noncompliance are license or registration suspension, revocation, or nonrenewal. Although some state licensing agencies have the capacity to immediately close a facility with a serious problem, such as child abuse or an environmental hazard, other states do not have such authority administratively. They must seek a court injunction, which is a lengthy process and depends on the expertise of

lawyers who may not be located within the state licensing agency, further inhibiting the process.

State agency personnel complain that enforcement actions are time-consuming and dependent on legal expertise, which is frequently in short supply (Kusserow, 1990). In dealing with cases of illegal child care, states frequently do not have the statutory authorities they need to close operations. Whereas some state agency personnel have the ability to enter unlicensed facilities to investigate complaints of illegal child care, other states do not even have a lawful right of entry in such cases. In addition, prosecution authority generally rests with local prosecutors and police departments hesitant to become involved in cases unless there is evidence that children are in imminent danger.

Although the topic of enforcement is sometimes politically charged, the reality is that states tend not to close child care facilities, even when chronically substandard. One of the reasons is the short supply of child care in some areas; another is the often fierce opposition of parents whose children's care settings are threatened with closure. Some parents side with providers no matter how bad their compliance records. Commentators have noted that even in the worst situations, parents have difficulty being critical of people to whom they have entrusted their children's care. After they have looked so hard to find child care, many do not want to start all over again (Hoyt & Schoonmaker, 1991). This explains why only 347 child care facilities, including family day care homes and child care centers, were closed in 1988 in the 21 states which reported data to the Inspector General's Office. (Kusserow, 1990).

Most state licensing personnel recognize that there is a small percentage of child care providers who cannot or will not comply with state health and safety standards and place children at risk of potential harm. For such providers, an enforcement action may be necessary. Failure to take such an action not only places children at risk but exposes states to possible lawsuits and ruins the reputation of other regulated providers who do comply with state regulations.

LICENSING AND THE CHILD CARE PROVIDER

While many child care providers and their associations understand the important role of state regulations in ensuring some minimal level of health and safety and in reassuring consumers of child care, other child care providers oppose licensing. For

example, in Virginia, large numbers of unregulated family day care providers lobbied the legislature to keep new laws from going into effect which would have included many unregulated settings in the Virginia licensing system. The argument of these providers, as well as church-exempt child care centers, who also are not subject to state licensing in Virginia, is that regulation would require them to raise prices beyond the reach of most parents or go out of business (Weaver, 1992).

Complaints that state regulatory schemes are too burdensome and too expensive are not uncommon among both regulated and unregulated day care providers. However, providers have a self-interest in a strong state child care licensing system. First, there are insurance advantages. The insurance industry is more willing to underwrite liability in a state with a good system of child care regulations and enforcement. Also, providers who are not regulated have considerably more difficulty in obtaining liability insurance to protect them from large judgments as a result of children's injuries while under their care.

In some states, liability insurance is available only to home day care providers who are regulated by the state. In Maryland, the state's highest court held that a business pursuits exclusion in a homeowners' liability insurance policy precluded payment for damages arising from the insured's family day care operation. As a result, the Maryland General Assembly passed a law requiring insurers in the state to offer child care liability insurance as part of a homeowner's policy to registered family day care providers. Providers who are not registered by the state have no such access to liability coverage, and are, in fact, operating at their own risk (§481 D, Article 48A, Annotated Code of Maryland).

Further, regulatory compliance is in a provider's self-interest because if a child should be injured accidentally, courts often look at state child care regulations and whether providers were complying with them at the time of the accident. Compliance with state child regulations at the time of an accident or injury is considered by some courts to be evidence of lack of negligence by the facility (Ghent, 1987).

A final advantage to child care providers of regulated status is the accessibility it provides them to funding sources. Receipt of federal funding is tied to compliance with health and safety standards under the Child Care and Development Block Grant statute passed in 1990. States regularly impose a set of requirements as a pre-condition to a facility's receiving payments for subsidized child care, even when the provider setting is other-

wise unregulated in the state. The federal Child Care Food Program requires compliance with state and local licensing regulations in order for a caregiver to receive subsidies for meals provided to children in day care.

THE PARENTS' ROLE

There is much discussion at both the state and federal levels regarding the role of parents in monitoring the quality of their children's care. Some would elevate parents into the role of monitors and evaluators of child care in hopes of deregulating and minimizing the government's involvement in this area. For example, in 1992, the state of New York undertook a program of cutting back on its regulatory oversight responsibilities under the state's child care laws by eliminating pre-operation inspections. The State instituted a campaign of consumer information and a complaint hotline for parents. Critics of the new law suggest that parents are no substitutes for inspectors as they are reluctant to complain because of fear of retribution by center staff against a child whose parent has blown the whistle (Sorensen, 1991).

Many experts who have studied the field of child care conclude that parents, in fact, are poor monitors of their children's day care. In *The Day Care Dilemma*, Angela Browne Miller concludes, based on her empirical study, that child care consumers as individuals are relatively unable to evaluate the quality of their child care services because their objectivity is obscured (Miller, 1990). The phenomena of parental denial and guilt has been noted by other observers.

Dr. T. Berry Brazelton, Professor Emeritus of Pediatrics at Harvard Medical School, explains that parents abdicate responsibility when they leave children in day care, not because they don't care, but because it hurts emotionally to care (Brazelton, 1985). Although protective services workers, police, and licensing officials found close to 50 mostly preschool children in a suburban house in Maryland, being watched by one lone teenager, parents of children in the illegal facility told the *Washington Post* (Hoyt & Schoonmaker, 1991) that they would take their children back that day except that the provider had been shut down. One parent reported she saw children at the illegal home but never took the time to count them. In another case, a parent contended that his baby-sitter was "great with kids," even though she had left his infant son unattended in a hot, locked car in a

wealthy suburb of New Jersey. The baby-sitter had driven to the dentist and, not knowing what to do with the baby, had left the baby locked in the car to be found sweating and screaming by a passerby (Hoyt & Schoonmaker, 1991).

On the other hand, while parents should not be the sole monitors and evaluators of their children's day care, they certainly have a significant role to play. In addition to child care providers and their staff, they are the only adults who are in the child care setting daily. State officials visit at most once or twice a year and then often announce visits. Although many parents appear to lack the expertise, the will, or the time to critique their children's care in any detail, most state licensing agencies have a complaint process for parents and do respond in some fashion to complaints.

In recognition of the role of parents in monitoring children's care, regulations implementing the Child Care and Development Block Grant mandate that states maintain a record of substantiated parental complaints and make information regarding such complaints available to the public upon request (45 Code of Federal Regulation §98.34). Few parents, in fact, take advantage of public licensing files to research the licensing history of day care facilities before making a selection, although most states currently make such information available. Most parents also fail to drop in on a child care setting unannounced, even though many state regulations require unlimited access by parents to the child care setting to observe their children. Finally, parents are generally unaware of their own state's licensing rules. They do not know what facilities are required to be regulated under state law or what the regulations are. By obtaining a copy of state law and regulations, the parent can check whether the facility is following the rules and encourage the provider toward compliance by discussing perceived violations with the director of the facility or complaining to the state. State agencies and the federal government are placing increased emphasis on consumer education as part of the mission of licensing (see Figure 3–1).

Another issue for some parents is their perceived indifference to whether the child care setting is regulated. Parents often do not realize the extensive background checking and inspection processes that some states undertake in the process of registering or licensing a facility. They do not consider that an unregulated caregiver may lack liability insurance so that if their child were injured in the facility, they most likely would not be compensated. In short, parents need to become as aggressive as consumers of child care as they often are of automobiles or other consumer commodities and services.

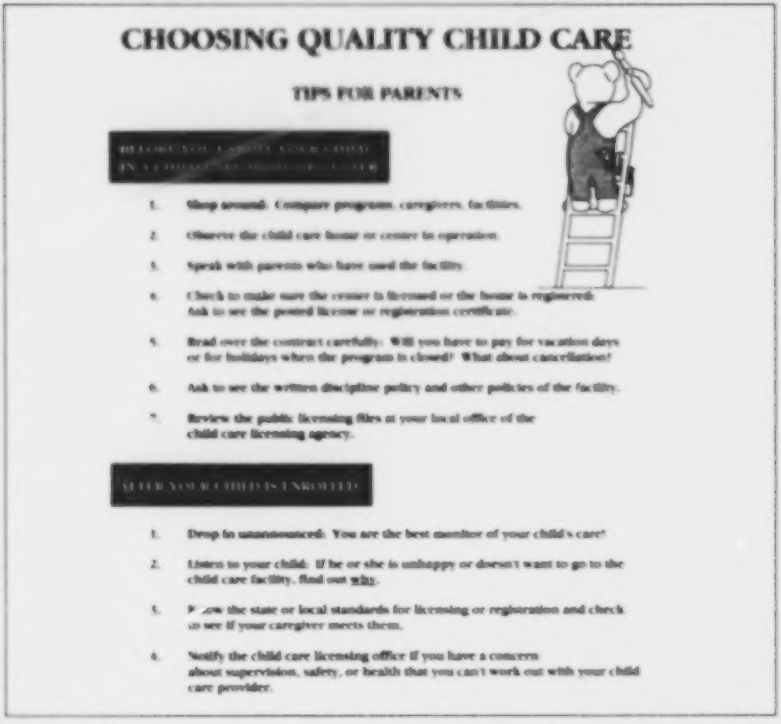
CHOOSING QUALITY CHILD CARE
TIPS FOR PARENTS
1. Shop around. Compare programs, caregivers, facilities.
2. Observe the child care home or center in operation.
3. Speak with parents who have used the facility.
4. Check to make sure the center is licensed or the home is registered. Ask to see the posted license or registration certificate.
5. Read over the contract carefully. Will you have to pay for vacation days or for holidays when the program is closed? What about cancellation?
6. Ask to see the written discipline policy and other policies of the facility.
7. Review the public licensing files at your local office of the child care licensing agency.
1. Drop in unannounced. You are the best monitor of your child's care!
2. Listen to your child. If he or she is unhappy or doesn't want to go to the child care facility, find out why.
3. Know the state or local standards for licensing or registration and check to see if your caregiver meets them.
4. Notify the child care licensing office if you have a concern about supervision, safety, or health that you can't work out with your child care provider.

Figure 3–1. Choosing quality child care.

THE FUTURE OF CHILD CARE LICENSING

Minimum National Standards

For a number of years, child advocates have promoted the concept of national standards for child day care, in view of the wide diversity of state regulation. One wonders why an infant born in Maryland, for example, should have the protection of a state-mandated ratio of one caregiver to every three infants in a child care center while an infant in Georgia or North Carolina must share one caregiver with six other babies.

For a long time, attempts on the federal level to pass a comprehensive child care bill included the concept of mandated national health and safety standards. However, the child care legislation which finally passed the U.S. Congress as Public Law 101-508, titled "The Child Care and Development Block Grant Act of 1990," did not contain federal licensing standards.

Instead, the Act was a compromise between those legislators who wished to improve the overall quality of U.S. child care by infusing more funds into the system while federally mandating a uniform level of state regulation and those who advocated a laissez faire "parental choice" system under which states would have a diminished role in regulating care. The legislative compromise produced a law which appropriated millions of dollars, primarily targeted at subsidizing child care for low and lower-middle income families, with some minimal requirements for state standard-setting.

Under the Block Grant statute, states are required to make available to parents and the general public, consumer education information about child care services, including any applicable state licensing and regulatory requirements and complaint procedures. Child care providers receiving funds under the law must meet existing applicable state or local licensing requirements, and providers not subject to state licensing must register with the state and comply with health and safety standards in three areas: infectious diseases, building and safety requirements, and training.

In spite of increased regulatory responsibilities, limited funds were made available to the states under the Block Grant statute to improve the licensing and monitoring of child care facilities. The Block Grant statute authorized 75 percent of funds to be used for child care services and for activities designed to improve the quality and availability of care. Federal regulations provide that only 10 percent of the 75 percent portion may be spent on administration and on activities to increase child care availability or improve quality. Only five percent of the total amount of a fiscal year's Block Grant funds may be spent on improving the monitoring of compliance with and enforcement of regulations, resource and referral programs, provider loans, provider training and technical assistance, or improving child care salaries and benefits (45 Code of Federal Regulation §§98.50 and 98.51).

As discussed above, many states exempt large numbers of child care settings from state regulation. However, for a caregiver in such a setting to receive Block Grant funds for a child in care, the state must register the caregiver and apply at least three sets of standards to the caregiver, unless the caregiver is an aunt, uncle, or grandparent of the child. Consequently, with limited administrative funds to carry out the new registration program, states could not be expected to provide more than minimal monitoring. In fact, the preamble to the interim final rule suggested that states merely collect names and addresses of previously unregulated caregivers who wished to receive payment (56

Federal Register 26194, 26208, June 6, 1991). The Block Grant statute and implementing regulations were a disappointment to those advocates who had strenuously advocated for uniform national standards.

At the same time that Congress rejected federal standards, a set of voluntary national standards was developed by the American Public Health Association in collaboration with the American Academy of Pediatrics. These standards, called "National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs," were published in 1992. The standards were developed by committees of medical and other professionals in specific areas to be used as models for states revising their regulations and for child care advocates advocating for the improvement of state regulations. These National Health and Safety Performance Standards include requirements in all the traditional areas generally covered by state regulations plus a few less common areas, such as parent relationships, health education, special facilities for ill children, transportation, and policies on child care for children with HIV infection. The National Health and Safety Performance Standards are regarded by many child care licensing professionals as comprehensive in their scope, their detail, and their attempt to ensure children's health and safety.

The Federal Role

The disparate and widely varying attempts of states to address the issue of ensuring safety and quality in child care is reminiscent of state nursing home regulation before the advent of the Medicare/Medicaid programs in the mid-1960s. The condition of patients in nursing homes prior to the passage of the Medicare/Medicaid statutes and the promulgation of federal nursing home regulations was deplorable. In fact, it was congressional oversight hearings and a growing national consensus of the need to strengthen protection for vulnerable older adults in such facilities that led to national regulation. Under Medicare and Medicaid, federal funding is tied to a facility's agreement to comply with federal standards and compliance is ensured by federal funding of state nursing home inspectors.

Over the years, federal monitoring of state inspections has increased, as has federal funding, with the perception that state agencies were not taking their oversight responsibilities seriously enough or enforcing sanctions against noncompliant nursing

homes. Overall, there is no question that the federal government's role in nursing home regulation has been beneficial.

Like the elderly in nursing homes, children in child care settings are a vulnerable population who are unable to advocate for their own interests or rights. One critical difference between nursing home patients and children is that the parents of children are in child care facilities on a daily basis, unlike the relatives of nursing home patients who often visit facilities infrequently. Day care children also leave for the day, whereas nursing home patients remain in the facility regardless of its quality 24 hours a day, some for the rest of their lives. Although there is more public scrutiny in child care facilities, during the major part of the day, working parents seldom visit and child care staff sometimes render less than adequate care. The fact that child sexual abuse on a large scale has occurred in some child day care facilities is an indication of the relative privacy afforded for potential child maltreatment (Finkelhor & Meyer, 1988).

There is little doubt that a more aggressive federal oversight role in child care is needed. In addition to minimum national standards established by the federal government, there needs to be a stable infusion of money into the child care system other than from the pockets of already over-burdened parents, if quality is to be improved on a national scale. The investment of public funds in child care is as important as investing in public school education. Child development experts agree that it is actually the earliest years of childhood, the preschool years, which are critical to a child's development, emotionally, socially, and cognitively.

What is needed in child care is both a funding stream to inject needed dollars into the system to encourage quality and a uniform, national system of quality assurance or regulatory oversight. The need for public infusion of dollars arises from the relative inability of private payers or parents to pay sufficient fees to give child care employers enough revenue to maintain a stable and trained workforce. In fact, child care employees are some of the poorest paid in the United States and are generally lacking health care benefits, retirement benefits, and other benefits that most American employees have learned to take for granted. As a result, staff turnover in child care facilities is extraordinarily high, promoting poor care for children. It is also apparent that the model of employer-supported child care has not flourished in U.S. industry because of the liability attached to providing child care on-site. If the federal government does not mandate that employers sponsor child care, as the federal government may do with

health insurance, then government has to do something else to create a system out of the chaos that exists in U.S. child care.

Alternative Systems

Edward Zigler of Yale University has advocated reforms which would use the existing public school system to organize a quality child care system in the United States. Under Dr. Zigler's plan, public schools would sponsor all-day, year-round child care for preschoolers from age 3 to prekindergarten, as well as before- and after-school and summer care for children from kindergarten through at least the sixth grade. The school system would also support a network for family day care providers by offering training and support and giving referrals to parents for younger children. Dr. Zigler calls for cash allowances from the federal government for new parents so that they can either stay home or use the money to pay for quality day care. However, some child care advocates do not believe that the public schools are the appropriate location for organizing a system of child care in the United States.

Whatever the solution to the dilemma of day care in the United States, it is clear there is a problem. It remains an open question whether licensing in the future will provide the solution to that problem by monitoring all facilities caring for children for compliance with a set of national health and safety standards, using sufficient numbers of well-trained inspectors.

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CHAPTER 4

HEALTHY CHILD CARE

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W. S. TAYLOR

WHY ARE INFECTIOUS DISEASES A PROBLEM IN CHILD CARE SETTINGS?

Disease Factors

In general, disease-causing germs exist in any environment, including homes, child care facilities, shopping malls, schools, and virtually any space where there are people or animals. As the number of people increases, the number of potential contacts relative to disease transmission increases proportionally. Child care settings offer an ideal site for transmission of germs because (a) children tend to have more upper respiratory illnesses each year than adults (Crosson, et al., 1986; Thacker, Addiss, Goodman, Holloway, & Spencer, 1992), (b) children are in proximity to others who may be harboring disease-causing germs (Thacker et al., 1992), and (c) young children are not likely to have developed hygienic habits.

Diseases of Concern

There are four groups of diseases of concern in child care settings (Aronson & Osterholm, 1984). First, children in group care are two to three times more likely to acquire certain illnesses primarily

affecting younger children, for example, *Haemophilus influenzae* (HiB). HiB is an upper respiratory infection which affects young children more frequently than adults. Fortunately, a vaccine, HBVC, which can decrease the likelihood of contracting this illness, can be given to children starting at 2 months of age (Shelov & Hannemann, 1991), but there are other illnesses affecting primarily preschool youngsters. Second, there are communicable diseases which can affect children and adults (staff and family members), such as viral diarrhea. Third, there are infections which cause few, if any, symptoms in young children, but can cause serious illness in adult staff or family contacts. For example, hepatitis A may cause mild "fever, nausea, vomiting, diarrhea, or jaundice (a yellowish skin color) in children, however, adults who contract this illness usually experience these problems to a much greater degree" (Shelov & Hannemann, 1991, p. 437). And last, there are communicable diseases with few, if any, health affects for children and many adults, but are potentially harmful to unborn children of pregnant women (Blackman, 1989; Pueschel & Mulick, 1990). Infections known to cause fetal damage (Williamson & Demmler, 1992) include rubella (German measles), cytomegalic inclusion disease (a viral disease), herpes simplex virus, human immunodeficiency virus (HIV) (Bale, 1990), and toxoplasmosis (a disease which can be transmitted by contact with cat feces or improperly cooked meat). Many child care workers are women of childbearing age who are concerned about infections that can harm an unborn child.

WHAT CAN BE DONE TO MINIMIZE THE TRANSMISSION OF COMMUNICABLE DISEASES IN GROUP SETTINGS FOR YOUNG CHILDREN?

Know How Diseases are Transmitted

To implement measures for controlling infection in a child care facility, it is important to understand how diseases are transmitted. If child care administrators or staff need information about routes of transmission, inservice education and printed materials often can be obtained from local or state health officials. In general, communicable disease transmission in child care settings occurs through (a) exhalation of respiratory droplets onto another person or object by regular respirations, sneezes, or coughs, (b) direct contact with an infected person or contaminated object, (c) poor hygiene after toileting and subsequent hand-to-mouth behaviors, or (d) contact with an infected per-

son's body fluids (Andersen, Bale, Blackman, & Murph, 1986). Some diseases can be transmitted in more than one way. For instance, Cytomegalovirus (CMV) can be transmitted by direct contact, oral-fecal contact, or respiratory droplets.

Collaborate With Public Health Officials

Child care administrators and workers can obtain valuable health information from state and local public health agencies and personnel. Public health professionals can offer general guidelines for minimizing disease transmission and other suggestions for healthy child care.

Some communicable diseases have been identified as potential community health problems. State and local health departments maintain lists of diseases which can affect communities and must be reported. Reportable diseases are usually grouped into three categories (a) diseases which can have considerable impact on public health and should be reported immediately (e.g., tuberculosis), (b) common diseases that have a substantial public health impact but do not require urgent reporting (e.g., hepatitis A), and (c) routine infections for which reporting is requested only during outbreaks (e.g., measles). A current list of reportable diseases is usually available from state and local health authorities.

Consider Environmental Factors

Settings for groups of young children can vary greatly and are affected by available resources. Information on environmental considerations can be obtained from national organizations concerned with child health and development. For example, the National Association for the Education of Young Children (NAEYC) and the American Public Health Association (APHA) (see Appendix for additional information) have developed environmental standards and guidelines for child care settings. Recommendations for space per child, number of lavatories per child, layout of food preparation facilities, class size, and amount of outdoor play area are offered. The Committee on Early Childhood, Adoption and Dependent Care of the American Academy of Pediatrics (AAP) (1987) offers the following suggestions:

1. Rooms used by children and staff should be large enough to accommodate a variety of activities without crowding.
2. Ventilation in all rooms should be adequate.

3. Temperature control mechanisms should be conveniently located for the staff.
4. Bathrooms should be readily accessible to children and staff.
5. Sinks, soap, and paper towels should be close to (or in) bathrooms for use after toileting.
6. Floors and walls should be made of materials that can be easily cleaned and disinfected.
7. Food preparation areas should be set apart from classrooms and bathrooms.

Research in child care facilities indicates that the following factors will minimize risks associated with communicable disease transmission (a) hand washing facilities that are readily available, (b) grouping of children by age, and (c) use of easily cleaned surfaces (Petersen & Bressler, 1986).

Designs for new facilities and modification of existing structures should address health concerns for staff and children. Local building code requirements and financial constraints often present challenges to development of a healthful environment. Also, finding an architect or space designer who is knowledgeable about space requirements and public health problems can be difficult. However, the long-term benefits of adequate planning relative to a healthy environment will have multiple benefits. Additional environmental suggestions are offered by Petersen and Bressler (1986):

1. Design child care centers around a central core containing food preparation areas, storage space, janitorial facilities, and toilet facilities.
2. Offices and conference rooms should be close to the front entrance.
3. Space for children's activities should be divided between rooms for infant and toddler care and "open" spaces for older children.
4. Infant and toddler rooms and food handling areas should be separated by walls from other areas in the building.
5. Kitchen surfaces should be chosen for ease of cleaning and durability. Use of stainless steel sinks, laminated plastic surfaces and cabinets, vinyl floor sheeting, and washable lead-free wall paint are recommended.
6. Food handlers should have separate bathroom and hand washing facilities with pedal operated sinks, liquid soap containers, and paper towel dispensers.
7. Floors in areas used by children should be carpeted or tiled with washable materials.

8. Since tile is more easily cleaned, eating should be restricted to tiled areas.
9. Diaper changing areas in infant or toddler rooms should be close to running water and restricted from use for other purposes.
10. Changing tables and shelves should be covered with laminated plastic for easy cleaning.
11. Toddler rooms should have appropriately sized "toilet training" fixtures and "junior" hand washing facilities.
12. Staff hand washing facilities should be readily accessible and have knee operated water controls, liquid soap containers, and paper towel dispensers.
13. All areas should be well lighted.
14. Furnishings should be covered with washable material.
15. Playground equipment should be washable and age appropriate.

All environmental planning relative to child care spaces should address health and safety issues for children, families, and staff. It also is important to note that facility planning is worthless unless good hygiene is practiced routinely.

Consider Staff Factors

Staff health is extremely important to minimizing the transmission of communicable diseases in group settings for children. Pre-employment medical evaluations, which specifically address health issues related to child care, should be required. At a minimum, health examinations should include (a) a history of infectious diseases, (b) a review of immunizations, (c) immunization where appropriate, (d) a physical examination, and (e) antibody testing regarding exposure to specific diseases (e.g., for measles, German measles, mumps, herpes, CMV, hepatitis, HIV). Child care administrators should be aware that any information obtained from a physician or other health practitioner, as the result of a medical evaluation, is confidential and may not be released unless the employee has given written permission. Health evaluation findings should remain confidential when transferred to an employee's file.

Provide Ongoing Staff and Parent Education

Recruitment and retention of qualified staff members can be an ongoing challenge in child care programs. Salaries for child care

workers have traditionally been low and benefits are usually minimal or nonexistent (Kendall, Aronson, Goldberg, & Smith, 1986). However, a well trained staff is critical to quality child care (Berk, 1985; Stallings & Porter, 1980) and minimizing communicable disease transmission.

New employees should be prepared adequately with knowledge and skills relative to developmentally appropriate practices (Bredekamp, 1986). Staff should have regular inservice educational programs and health issues should be addressed, including communicable disease transmission, communicable disease prevention, recognition of illness in children, behavior management, nutrition, care and education of children with disabilities, and first aid procedures.

To promote parent-staff collaboration and increase parent understanding of health issues, it would be advisable to invite parents to inservice programs. Due to the frequency of illness in young children, communicable disease transmission is inevitable. Parents should be informed of the possibility of illness as a result of group contacts. It also is important to provide parents with information regarding each family's responsibility for informing center staff of symptoms or illness in their child. When enrolling children in a child care or educational program, parents should be provided with written materials containing center policies regarding communicable diseases and parent responsibility for notification of center staff.

The following issues should be considered for training purposes (a) relationships between child physical health and emotional well being, (b) prevention, identification and management of infectious diseases in children, and (c) adult health issues (Kendall et al., 1986). Inservice sessions could be supplemented with written materials. For example, materials developed by the U.S. Department of Health and Human Services (1984) could be shared with parents and staff.

Engage A Health Consultant

Due to the frequency of illness in group settings for young children and the importance of rapid recognition and management of infectious diseases, each center should consider retention of a health care consultant. Pediatricians, pediatric nurse practitioners, family nurse practitioners, family practitioners with pediatric experience, and public health nurses are logical sources of consultative services. In general, their role is not the diagnosis or treatment of

ill children, but to provide communicable disease oversight. Health care consultants can perform a wide variety of services. They can review child health records for evidence of annual physical examinations by primary physicians, health problems which might affect other children or adults, health issues warranting special attention (e.g., dietary restrictions), and compliance with state or local immunization guidelines. A consultant can also review health records of current and prospective employees for evidence of pre-employment physical examinations, completeness of immunization records, relevant antibody testing, antibody status of women of childbearing age, and health conditions with potential health consequences to others.

Health consultants should monitor occurrences of communicable diseases based on regular reports from the child care center. In the event of a communicable disease outbreak in a child care setting, it is important for health consultants to gather and interpret relevant medical information for purposes of making specific recommendations. For example, if an outbreak of hepatitis A occurs in a center, a health consultant might be expected to coordinate notification of local public health officials, administration of immune globulin to contacts, notification of families, notification of other physicians in the community, and implementation of other health measures necessary to control the outbreak.

Group Children Appropriately

For health reasons, children should be grouped by age, toileting status, and infection status. Infants and toddlers are usually not toilet trained and are more likely to spread infections through saliva, urine, and feces. Children who have not acquired toileting skills should be separated from children who are toilet trained. Children who become ill while at the care center should be kept apart from children who are not ill. Although it is likely that germs responsible for an illness contracted by a child at a center have already been spread to several other persons before symptoms appear, it makes good sense to separate ill children until they have been picked up by their parents or a medical evaluation has been performed.

Provide Administrative Guidance

A written policy manual is the structural backbone of a child care program. Policies related to health care should be included. State and local health regulations pertaining to child care, guidelines

for obtaining health consultation, sick child care, staff illness, procedures for disinfecting rooms or materials, and exclusion of ill children or adults should be clearly delineated. Also, policies should be included for contacting families of children who return to child care centers following an illness. Information regarding the likelihood of recurrence, route of transmission, and special precautions to minimize potential transmission should be sought. This can be facilitated through good communication with families, primary health care providers, and public health officials.

Contrary to popular belief, there appears to be no evidence that children prolong their recovery by attending school while mildly ill, if staffing is adequate. Many communicable diseases are transmitted before symptoms appear. Therefore, some exclusion policies may not be effective in preventing contagion. If mildly ill children can be cared for without compromising the health and care of others, exclusion may not be warranted according to Shapiro, Kuritsky, and Potter (1986).

There are certain diseases which require an affected child to be excluded from a care setting (Georgetown University Child Development Center, 1986). State or local health officials should be consulted when determining diseases warranting exclusion. Some that should be considered are depicted in Figure 4–1.

Sick child care policy and exclusion policy should be clearly written and distributed to parents on their first visit. A written policy regarding care of children who become sick is very important. The language should be simple, direct, and easily understood by parents. Creation of this kind of policy can be an arduous task. It should address state or local public health regulations, space and personnel requirements, and recommendations from a health consultant. When possible the policy should reflect awareness of family expense for home care for sick children, parental leave policies related to ill children, and the unpredictable nature of communicable diseases in young children. There is no standard policy that is acceptable to all providers of child care because of differing physical facilities, number and qualifications of personnel, and needs of parents being served.

Comply With Child Care Regulations

Most states have regulations, albeit varied, for the following health practices (a) hand washing, (b) employee health examinations, (c) use of personal toilet articles, (d) medical record keeping, (e) health related admission procedures, (f) isolation of ill children or adults, (g) return to care after illness, (h) notification

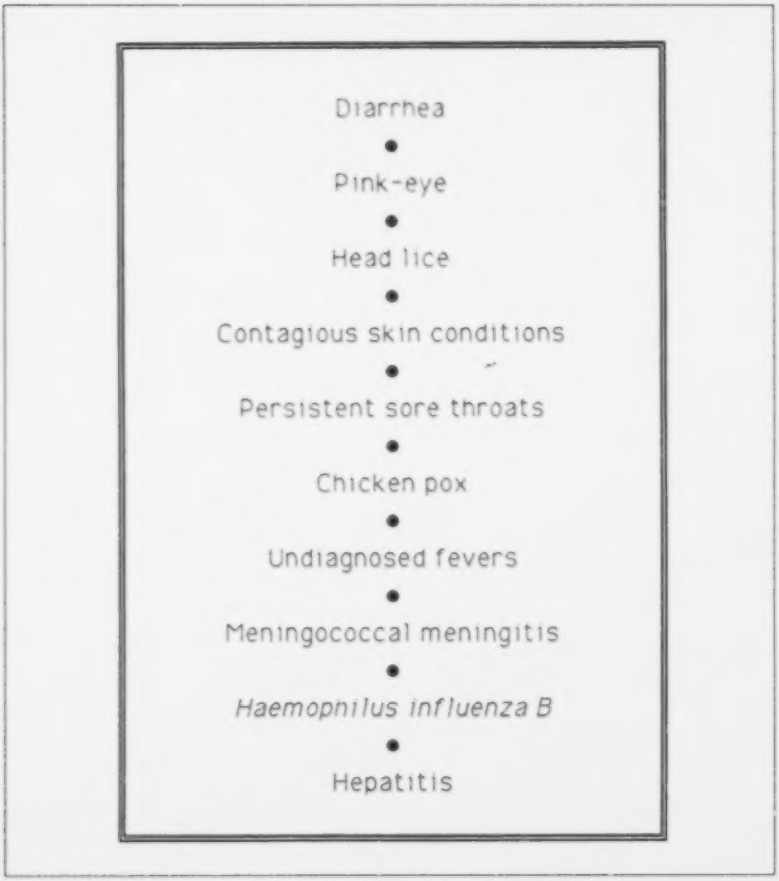

Figure 4–1. Illnesses on many child care exclusion lists.

of parents concerning outbreaks of communicable diseases, (i) reportable diseases, (j) adult to child ratios, and (k) group size (Morgan, Stevenson, Fiene, & Stephens, 1986). It is important for administrators to be knowledgeable about regulatory requirements in their state and ensure that all staff comply with regulations affecting child, family, and staff health.

Practice Good Hygiene

Although illness is inevitable in child care settings, good hygiene can contribute to reductions in frequency and duration of com-

municable diseases. To this end, certain procedures should be followed routinely. These procedures should be delineated in policy manuals after careful analysis by a health consultant. Creation of a sterile environment for children and staff is not likely. By nature, social activities for children will involve transmission of microorganisms from one child or adult to another. As educators, related services staff, and day care providers strive to provide a safe and healthful environment for young children, certain procedures should be performed routinely. For example, cloth serves as a rather effective barrier to the transmission of disease-causing germs. Smocks can serve as a protective layer between a staff person and potentially infectious particles. Chlorine bleach diluted in water is an inexpensive disinfectant when used on washable surfaces. The importance of proper disposal of potentially infectious waste matter (e.g., soiled diapers, used tissues) should be emphasized. Some suggestions for safeguards can be found in Figure 4–2 (Taylor & Taylor, 1989).

Commercial disinfectant or a solution of 1/4 cup of liquid household bleach in one gallon of water may be used as a disinfectant. This concentration of bleach will inactivate hepatitis A virus, HIV, and many other disease-producing microorganisms. A similar concentration of bleach should be available in a pump spray bottle for application to small, or hard-to-reach surfaces. Washed surfaces can be left to air dry or, after 20 minutes, can be rinsed with clean water and then left to air dry. **Bottles and storage containers of disinfectant, bleach, or bleach solutions should be clearly labeled and sealed with child resistant caps and kept out of a child's reach.**

Although there are several excellent sources of information concerning communicable diseases and young children in group settings, one highly recommended informational packet is offered by the U.S. Department of Health and Human Services (1984). This publication is actually a kit containing general information about contagious diseases, vaccine preventable diseases, a handbook for child care directors, a handbook for caretakers, and one for parents. The kit also has suggestions for prevention and management of illness and posters illustrating signs of illness in children, proper hand washing technique, and proper diaper changing methods. The director's handbook addresses policy, organization, parent education, immunization records, problems of sick children, and supervision. The caretaker handbook offers suggestions for activities to control communicable diseases, and the parents' handbook covers prevention and

Wear a clean smock daily
•
Wash play surfaces and toys with disinfectant daily
•
Sweep floors and mop with disinfectant daily
•
Collect trash in plastic bags which are sealed at the end of each day
•
Dispose of trash bags daily
•
Send soiled cloth diapers home in sealed plastic bags daily
•
Clean walls with a disinfectant weekly

Figure 4–2. Suggestions for minimizing the transmission of disease.

management of illness. This publication can serve as the basis of a communicable disease control program and is, therefore, highly recommended.

Require Appropriate Hand Washing

A review of literature related to communicable diseases and young children in group settings reveals a common theme. **Hand washing** is the single most effective procedure for prevention of transmission of communicable diseases (Committee on Infectious Diseases, American Academy of Pediatrics, 1987). Hand washing should be performed by child care providers at the times indicated in Figure 4–3, and hand washing reminder posters should be placed in each lavatory.

To wash hands properly, remove jewelry, wash hands with liquid soap under running water, using plenty of friction, and

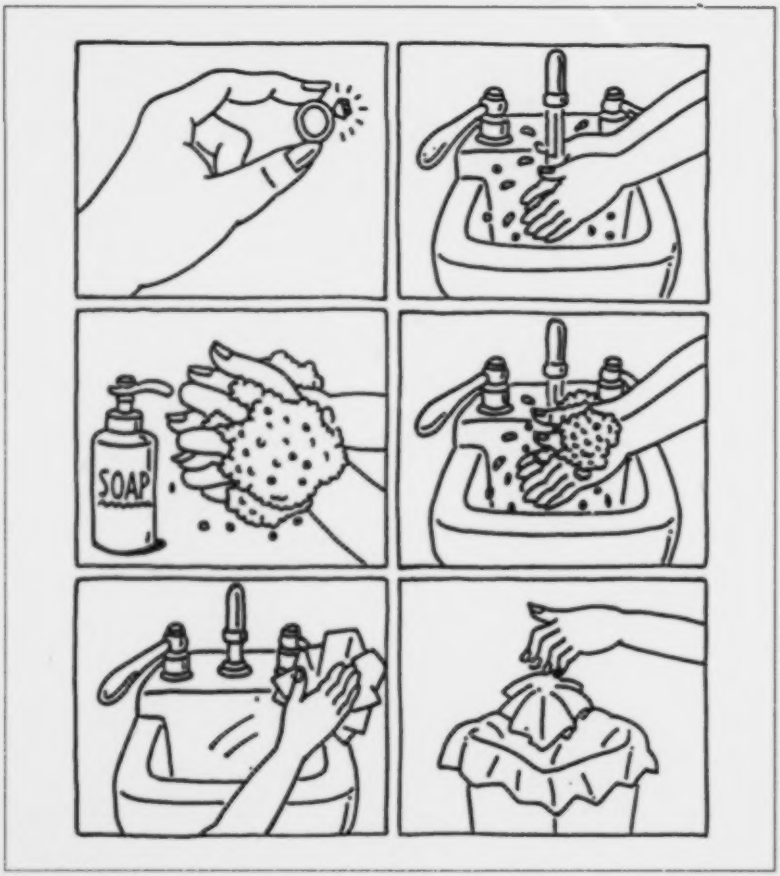

Figure 4–3. Proper hand washing.

covering all skin surfaces to the midpoint of the lower arm. After thorough rinsing, hands should be dried with paper towels. Hand washing at a sink equipped with knee or foot pedals is preferable to avoid touching contaminated surfaces with clean hands. When this is not possible, it is acceptable to turn on faucets with "dirty" hands, wash and dry hands, then turn off faucets with paper towels. The faucet fixture can be sprayed with disinfectant after hand washing. If performed properly and as frequently as recommended (see Figure 4–4), many workers will develop dry, cracked, and chapped hands. These breaks in the skin can be sources of entry of microorganisms into the body.

Figure 4–4. Hand washing times and situations.

Preventative measures such as the liberal use of skin creams and lotions are, therefore, recommended.

Use Proper Diapering and Toileting Techniques

Diaper changing is a procedure which carries risks of contamination for the child, caretaker, and environment (Child Day Care Infectious Disease Study Group, 1984). The use of universal precautions are appropriate for care providers who are responsible for infants and toddlers. This means performing tasks as though all recipients are infected. Because there are many communicable diseases which are asymptomatic, infectious during the incubation period, or involve "shedding" of germs via body fluids, it makes sense to be cautious with all children. In the context of diapering and toileting, universal precautions involve procedures that would be used if each child was infected with a communicable disease transmitted through stool or urine. Gloves should be

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used for diaper changing, clean-up procedures, and toileting assistance. Disposable gloves may prove expensive, but thicker "dish washing" rubber gloves could be washed and disinfected between uses. Diaper changing must be confined to designated areas separate from food preparation and serving areas.

Diaper changing locations should have easily cleaned surfaces and be accessible to a sink. A disposable cover should be used on the diaper changing surface and discarded after one use. Contaminated paper products should be disposed of in sealed plastic bags. The changing surface should be washed and disinfected after every procedure. Soiled diapers should be placed in plastic bags and stored in covered trash cans. Soiled clothing also should be placed in plastic bags, sealed and stored in a covered container until it can be picked up by the parents for laundering at home. Finally, before returning to the classroom from the toilet or diapering area, both care providers and children should wash their hands.

Clean Up Body Fluid Spills Safely

It is relatively common for young children to have bloody noses or occasional small cuts which bleed. Children may also spit, vomit, or have toileting accidents. Because some microorganisms are spread through these body fluids, thorough clean up of blood, vomitus, mucus, urine, and feces should occur immediately following an incident. Again, universal precautions are appropriate for cleaning up body fluid spills. The use of thick rubber gloves is advisable. Initially, spills should be wiped up with paper towels which are then discarded. The area then should be washed or mopped with soap or detergent and rinsed. Disinfection, as previously described, should follow all spills of body fluids (see Figure 4–5).

Handle Food Properly

The American Academy of Pediatrics recommends hiring a professional sanitarian to review food-handling practices and equipment (Committee on Early Childhood, Adoption and Dependent Care: American Academy of Pediatrics, 1987). Consultation by a professional sanitarian should be sought even if state and local regulations do not address this issue. Policies relating to food storage, preparation, transport, and clean-up procedures could be reviewed by a health care consultant. Of particular concern

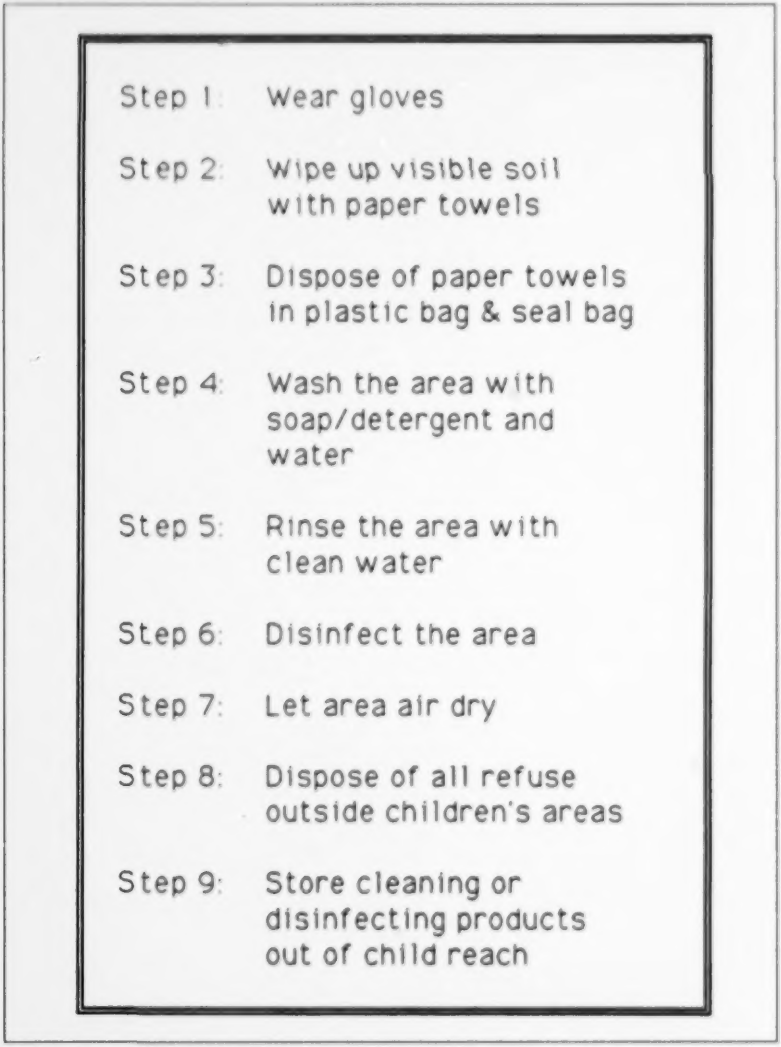
Step 1: Wear gloves
Step 2: Wipe up visible soil with paper towels
Step 3: Dispose of paper towels in plastic bag & seal bag
Step 4: Wash the area with soap/detergent and water
Step 5: Rinse the area with clean water
Step 6: Disinfect the area
Step 7: Let area air dry
Step 8: Dispose of all refuse outside children's areas
Step 9: Store cleaning or disinfecting products out of child reach

Figure 4–5. Procedures for cleaning spills of body fluids.

are policies related to handling of infant formula and commercial baby foods. Food preparation and service should be provided by workers who are free of skin lesions and who have no responsibilities for the care of infants or toddlers.

Maintain Confidentiality

Many states have regulatory requirements for confidentiality. If a child has a communicable disease (e.g., hepatitis A), a center's staff is expected to hold that child's identity in confidence. However, there is also an obligation to provide a safe and healthful environment for all children attending the program. To protect the rights of children who are ill while protecting the rights of other children, it is important for administrators to develop careful policies, procedures, and staff training programs covering these issues.

Even the most vigilant efforts will not prevent all illness. When an outbreak occurs, parents should be notified promptly while maintaining appropriate confidentiality. It is imperative that other families receive information regarding the possibility of infection. To avoid a breach of confidentiality, a general letter containing a description of the illness should be sent to all families of children enrolled at the center. Information about the illness, its characteristics, modes of transmission, likelihood of infection, and precautionary or treatment measures should be included in the letter. If informative materials are prepared prior to an outbreak, they can be distributed in a timely fashion without violating confidentiality. Excellent examples of parent letters (see Figure 4–6) and information sheets can be found in *Health in Day Care: A Manual for Day Care Providers* (Georgetown University Child Development Center, 1986).

Responsibilities of Program Directors

Program directors are responsible for establishing standards of education or care. Standards usually are defined in policies or procedures manuals which provide written assurances of a particular course of action (Linder, 1983). Program standards generally should be consistent with nationally accepted standards and practices throughout the field (Brown, 1984; Decker & Decker, 1984). Virtually all national models address health and safety issues. Model standards and practices have been developed by a variety of national and state organizations including The National Association for the Education of Young Children (NAEYC), American Public Health Association (APHA), and American Academy of Pediatrics (AAP). Addresses and phone numbers of these organizations can be found in the Appendix.

Professionals from the American Public Health Association (APHA) collaborated with colleagues of the American Academy of Pediatrics (AAP) to develop national health and safety perfor-

Date:

Dear Parent or caretaker:

A child (or adult) from our center has contracted hepatitis A.

WHAT IS IT? Hepatitis A is an infection of the liver and may cause fatigue, elevated body temperature, poor appetite, nausea, or jaundice (yellowing of skin or eyes). Hepatitis A usually lasts for a week or two. Young children may have very mild symptoms or none at all.

HOW IS IT CAUGHT? Hepatitis A is caused by germs in the intestines and stool. Hepatitis A germs are passed in stool. If an infected person does not wash hands thoroughly after toileting, the virus can spread to other people, food, or objects. Two to eight weeks after being infected, a person may develop hepatitis A. This illness is diagnosed by a blood test. Hepatitis A may be prevented by a shot of immune globulin.

WHAT SHOULD BE DONE?

1. Make sure everyone washes their hands thoroughly after using the toilet, helping a child use the toilet, changing a diaper, cleaning up toilet accidents, and before touching food (or eating).

2. If anyone in your home develops symptoms, have them see a physician right away and tell their health care provider about this letter.

3. Ask your health care provider or a local health department official if you or other family members should have a shot of immune globulin.

If you have any questions, please contact your health care provider or the local health department.

Figure 4–6. Sample letter to parents.

mance standards for out-of-home child care programs (American Public Health Association, 1992). Of the 10 public health issues addressed in this publication, a number are particularly relevant to communicable diseases and group settings for young children, including (1) environmental quality, (2) prevention and control of infectious disease, (3) general health (of children and families), (4) staff health, (5) children with special needs (including children with chronic illnesses), and (6) health and safety organization and administration. APHA standards should provide guidance for those who strive to minimize the risk of transmitting communicable diseases in group settings for young children.

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Georgetown University Child Development Center has published important information (e.g., Pokorni & Kaufmann, 1986) related to minimizing the spread of communicable diseases among young children, their families, and staff. *Health in Day Care: A Manual for Day Care Providers* (Georgetown University Child Development Center, 1986) provides an enormous amount of information, including exclusion guidelines, suggestions for ways of notifying families during an outbreak, and suggestions for development of a "get well room" to be used by children who need to be isolated due to illness.

SUMMARY

No amount of planning, money, scientific research, or design will eliminate infectious diseases from child care centers. However, there are precautions and routines designed to decrease the incidence and severity of infectious disease in group settings for young children. To this end, setting design, staffing, policy development, ongoing staff and family education, and implementation of policies and practices which support good health can be effective in preventing or limiting the spread of communicable diseases.

Recommendations for any group setting involving young children should include development of cleaning and disinfecting routines, hand washing policies and procedures, diapering and toileting techniques, management of body fluid spills, and disposal of soiled materials. Care providers should have a thorough knowledge of center health-related policies and practices and awareness of other factors influencing child health.

GLOSSARY

Carriers: Individuals who are infected by an organism but are not "sick" and, therefore, have no symptoms or signs of illness.
Contacts: Persons known to have been in close proximity to, and presumably exposed to, an infected individual or objects handled by the infected person.
Disinfectants: Chemical sanitizing agents, usually liquids, which inactivate or kill disease-causing particles (microorganisms).
Germs: Microscopic particles (microorganisms) which can cause illness.
Incubation period: The time interval from the entrance of an organism into a person (host) until sickness is apparent.

Infect: The entrance of a disease-causing germ (microorganism) into or on a person's body.
Infectious diseases: Illness that can be transmitted; they are also known as communicable.
Shedding: The continued excretion of infectious particles, often persisting for long periods of time, even after the illness has subsided.
Signs: Objective manifestations of disease, such as fever, jaundice, or rash.
Symptoms: Subjective complaints of a person afflicted with a disease, such as pain or weakness.
Universal Precautions: The actions taken as if all recipients of the service were infected, even in the absence of signs or symptoms of illness.

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CHAPTER 5

MEETING THE NEED: CHILD CARE RESOURCE CENTERS

SANDRA SKOLNICK

More people, organizations, and businesses across the United States are turning to resource and referral centers to meet the increasing need for child care. Although child care resource and referral centers do not directly provide care, they do create an infrastructure of support services for the child care delivery system. These services are offered on a community basis, but can be coordinated by regional or statewide offices and work as well in urban areas as in rural and suburban areas.

The primary goal of resource and referral centers is to offer community-based services that strengthen and expand child care resources. Centers pull together the various shareholders in the child care delivery system, including parents, child care providers, employers, unions, governments, and civic, charitable, and advocacy organizations (Maryland Employers Advisory Council on Child Care, 1988). Working with all these groups, centers design services to stimulate the supply, enhance the quality, and increase the accessibility of local child care resources through a range of activities:

- Recruitment and continuing training of providers,
- Technical assistance to employers and child care programs,
- Resource and referral counseling for parents seeking care,

- Parenting education, and
- Data collection and community education

This chapter focuses on five major aspects of meeting the need for child care:

1. Locating child care in the community,
2. Staffing and personnel training,
3. Interagency approaches,
4. Environmental settings, and
5. Funding: resources for providers and families.

The role of child care resource centers (CCRCs) is described in general terms for each aspect. The type of services provided by specific CCRCs vary according the needs of each community.

LOCATING CHILD CARE IN THE COMMUNITY

Berezin (1990) describes the search for child care as "a journey through a thorny maze." The search may begin with a notice on a bulletin board, a telephone number in the classified ads, a sign on the road, or a listing in the Yellow Pages. These may yield solutions, but often are inappropriate and only add to the frustrations of working parents. There are dedicated caregivers and excellent programs in every community. Helping parents find appropriate child care becomes a joint effort among the shareholders of the child care delivery system.

In the past, in traditional American families, fathers went to work and mothers stayed home to care for the children. Now over half of all women in the United States with children under age six are in the work force. This trend is unlikely to decelerate. Women are expected to account for two thirds of the net increase in the labor force by the year 2000. Child care services, however, have not kept pace with these rapid social changes.

In many parts of the United States, market forces have stimulated the expansion of child care in suburban areas. Similar growth, however, has been stymied in urban and rural areas, where many of the poorest citizens live. Stimulating the supply of child care is not a simple task. Initiatives include providing technical assistance for start-up and program enhancement, finding underutilized public space for child care services, changing laws and zoning ordinances that hinder child care expansion, and dispensing grants and loans for capital expenditures (Maryland Committee for Children, Inc., 1989).

There is an increasing awareness in the business community and among government leaders of the need for a good child care delivery system. Berezin (1990) notes that the lack of accessible and affordable child care has been recognized at the federal level as a crisis in the United States. The two major political parties continue to have a child care plank in their platforms, and many child care bills are regularly introduced at the federal and state levels.

Where to Begin Looking for Child Care

In the early 1970s child care resource and referral centers began bridging the gap between parents needing child care services and those providing them. Many resource centers were formed by parents who were trying to find quality child care for their children. From this beginning, centers began to address other child care needs, including advocacy, training and technical assistance (LOCATE, 1991).

Gwen Morgan, a professor at Wheelock College, envisioned resource centers that provide support to parents, providers, and the community without centralizing control or adding layers of management. A decentralized structure, she argued, would allow for creativity, local variety, and a high degree of autonomy without sacrificing quality. Resource centers should be nonprofit organizations funded with private and public moneys. Morgan said (Maryland Employers Advisory Advisory Council on Child Care, 1988):

> What I believe is that it's easier to achieve quality when you have small programs. We simply can't afford not to use the resources we have. There is a lot of good child care out there. But we can improve it, link it up with an efficient system, make it more accessible and expand it. (p. iii)

The first step in the search for quality child care is finding out if the community has a resource and referral center. Child care resource centers (CCRCs) often advertise services in local papers or by posting notices at public buildings, such as the post office or library. CCRCs also may be listed in the telephone book. Many local governments, especially those with agencies responsible for children's issues, can provide information about available resource and referral services.

Specially trained counselors at CCRCs work with parents to find the child care that is best suited to their children's needs.

First they help parents define the family's practical needs. In Figure 5–1 benefits of a resource and referral center are detailed.

They may ask the ages of the children needing care, the hours of care needed, how much the family can afford, and desired location (near work, home, or school). Counselors have access to data bases to tell parents what is available, what are the costs, and problems specific to a community or area (Berezin, 1990).

The CCRC does not recommend or place children in child care programs or homes. Counselors will provide a list of possible placements that meet the primary criteria outlined by parents. The right of parents to choose the child care most appropriate for their child and family is carefully preserved (Maryland Employers Advisory Council on Child Care, 1988).

What Should Be Asked?

Choosing child care is a difficult decision that only the parent can make. CCRCs can provide information about child care options, regulations, and child care programs and providers near home, work, or schools. For example, the Statewide Child Care Resource Center in Maryland has developed pamphlets to help parents select appropriate child care (Choosing, 1991). The brochure outlines the following six-step process to help parents make their decision:

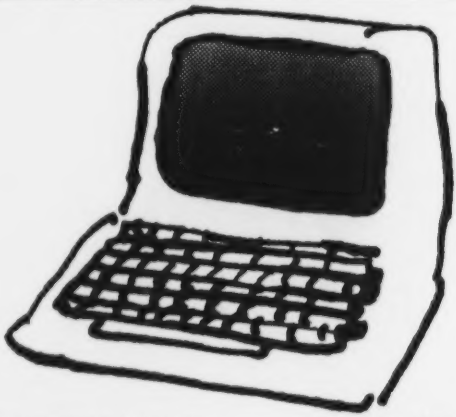
1. Call: Call the providers in the family day care homes or centers provided by the CCRC. Tell them you received their names from the CCRC and you are looking for care for your child. Ask them:

- What time do you open and close?
- Do you serve meals or do I need to bring my child's own food?
- When I have the time, can I stay and see my child play?
- I would like to come and visit your home (or center). What day and time would be best? Please give me directions (if needed).

2. Visit: Visit at least three programs. When you go, look at the area, the caregiver(s), and the children. Check the following items:

Look at the Area

- Does it look clean and safe for every age child there?
- Is there enough space inside and out so all the children can have room to play?



LOCATE, a computerized child care resource and referral service, enables companies to effectively assist their employees in finding child care services best suited to their needs, preferences and ability to pay. This service includes counseling and information on choosing child care.

Employees of companies who purchase the use of LOCATE will benefit in the following ways:

1. Individual counseling and assessment of employees' child care needs and matching of these needs with available programs
2. Direct access, via a private corporate subscriber telephone line, to LOCATE's daily updated data-bank which care programs throughout the Baltimore metropolitan area, Anne Arundel, Howard, and Washington counties
3. Receipt of the following informational materials:
   a. an easy-to-read, current computer printout listing available programs
   b. one page detailed narratives for each program listed which provide in-depth information about the services offered
   c. a comprehensive brochure entitled, "Choosing Child Care"
   d. specialized informational materials regarding federal programs designed to assist those in need of child care (e.g. tax credits and financial assistance)
4. Continuous child care placement follow-up advice until all community resources are exhausted
5. Optional additional individualized sessions with a trained LOCATE counselor to further explore child care concerns
6. Optional scheduling of parental visits to prospective child care facilities
7. Peace of mind that their children are receiving the best care available! LOCATE will also provide a corporate subscriber with information about its employees' preferences for child care and the availability of programs in the community. Information gathered by LOCATE will help your company determine if there is a need for additional corporate child care involvement, such as employer subsidized child care, on-site child care centers and/or parenting seminars.

Figure 5–1. Sample resource and referral information. Copyright© Maryland Committee for Children, Inc. Reprinted by permission.

- Are there enough toys and materials for all the children?
- Can the children reach the toys easily?
- Is there a time each day for both quiet and active play?
- Ask to see the provider's license.

Look at the Caregiver

- Does the caregiver seem happy to meet your child?
- Does the caregiver use a calm voice and talk to the children on their level?
- How does the caregiver discipline the children?
- Does the caregiver seem to enjoy the children?
- Do I feel good about leaving my child with this person?

Look at the Children

- Do the children look happy? Are they playing nicely?
- Are they given a chance to make choices?
- Can I picture my child playing happily here?

3. Ask: Ask the caregiver if you may talk with other parents who use that home or center. Get several names and phone numbers and call these parents. If the center is not able to give you this information, go to the center at drop-off or pick-up times to talk with some of the parents. Ask the parents:

- Are you happy with your child's care?
- Does your child enjoy going there?
- What do you like the most about this child care?
- What are some of the things that you don't like?
- If you had to find care again, would your child still go there?

4. Decide: Decide which child care home or center seems the best for you and your child.

- Go over your notes from all the questions you have asked.
- If you feel unsure about a program, visit again. If you are unhappy with all the choices, call the CCRC again for more names. If care is hard to find, you may need to try a new area.

5. Act: Act on the hints listed below. They will help you feel good about the care you have chosen.

- Sign a contract before you start care. This helps you and the caregiver avoid surprises. Include the hours the program opens and closes, the days the program will be closed, and the things you need to bring to the program.

- Get involved; it is the best way to feel comfortable in a new program. Help with an arts and crafts project, bring in snacks for parties, and get to know the teachers and other parents.
- If you are pleased with the care your child receives, tell the provider! Good parent/provider communication benefits your child.

6. Help!: If you have concerns about the way your child is treated, speak to the caregiver. Feel free to call the CCRC counselor as a resource for more information. If you feel the program is not operating according to regulations, contact your local, regional, or state regulatory agency.

STAFFING AND PERSONNEL TRAINING

One of the critical issues facing the child care community is how to attract and retain trained staff. One of the CCRCs' key roles is that of documenting the staffing and training issues facing the child care community and developing strategies for improvement.

Child care workers are among the lowest 10 percent of wage earners in the United States. In 1989, the Child Care Employee Project (CCEP) released the results of the most comprehensive study of child care center staffing in over a decade. The National Child Care Staffing Study (Whitebrook, Howes, & Phillips, 1989) explored "how teachers and their working conditions affect the caliber of center-based child care today" in Phoenix, Atlanta, Boston, Seattle, and Detroit. The study found that "despite having higher levels of formal education than the average American worker, child care teaching staff earn abysmally low wages" (p. 4). The average hourly wage for child care workers in the five cities surveyed was $5.35.

Child care professionals earn less then half as much as comparably educated women and less than one third as much as comparably educated men in the civilian labor force. Nationally, over 56 percent of child care professionals earn less than workers at fast food restaurants. In the last decade, child care staff wages, when adjusted for inflation, decreased more than 20 percent

Moreover, most child care employees also do not receive the benefits available in many other professions. In a survey conducted in Maryland, health benefits were not provided to 55 percent of the center staff that were surveyed, benefits were not available at all to 44 percent; benefits were available but paid in full by employees for another 11 percent; and health premiums were paid or partially paid for 45 percent (*Shortchanging Our Children*, MCC 1992).

Training

Child care professionals—including family day care providers, child care center staff, and teachers in Head Start, nursery schools, and private and public school settings—need access to low cost, quality training that will enable them to understand and meet the needs of children. Such training is provided by the resource and referral center through a variety of means, including workshops, conferences, and newsletters.

In many areas, child care providers depend on programs offered by CCRCs to meet state licensing requirements for continuing training and to increase their skills and abilities to care for young children. These requirements vary depending on the nature of the program operated and the state in which the program is located. This training is most effective when delivered with community input by local professionals who are responsive to the specific needs of their communities (Maryland ChildCare Resource Network, 1991).

Research, widely accepted and recognized within the field of early childhood education, indicates that one of the key attributes of quality child care is the level of staff training (Ruopp, Travers, Glantz, & Coelen, 1979). It has also been demonstrated that continuing training has a significant positive impact on child care staff retention. This results in continuity of care, an important factor in the social and emotional development of young children (Ruopp, et al., 1979).

Training sessions for child care providers address the theoretical, philosophical, and practical aspects of child care. Quality training programs encourage professionalism, increase staff retention, and promote competence, success, and satisfaction in the child care field. Topics that meet these criteria include:

- Child growth and development;
- Program planning and implementation of developmentally appropriate curricula for children from infancy through school age;
- Integration of children with special needs into early childhood programs;
- Parent/provider relationships;
- Professional awareness and development; and
- Administrative and business aspects of managing family day care programs and child care centers.

Through these courses, child care professionals gain an opportunity to hone their skills, to share ideas and experiences with their colleagues, and to advance their professional certification.

Training is also made available to child care professionals in their own programs, by their professional associations, by individual educational consultants, and by two and four year colleges. Many states are beginning to develop comprehensive plans for the training of child care workers to maximize available training.

In addition, resource and referral centers provide parent training on certain child-related issues to help parents to determine appropriate techniques for dealing with young children. Figure 5–2 illustrates a sample advertisement to attract the attention of parents.

INTERAGENCY APPROACHES

Developmentally appropriate, quality preschool programs are important for young children. Quality preschool programs can help children learn important socialization skills, improve communications skills, adjust to school rhythms and routines, and lay the foundation for school success.

Preschool programs at the federal and state levels are currently benefiting millions of children across the country. Some of these programs, such as Head Start and state-funded preschool

DISCIPLINE: TEACHING CHILDREN SELF-CONTROL

(A FOCUS GROUP ESPECIALLY FOR PARENTS WITH CHILDREN UNDER 6)

April 22 (Thursday)
12:00 - 1:00 p.m.
Severn

Bring your own lunch; we will provide dessert & beverage

For all employees.
Call Maureen (ext. 1605) to register.

Discipline involves more than enforcing rules. Children need our help in learning to respect themselves and get along with others. This workshop, conducted by Amy Bloom Connolly, Maryland Committee for Children, will provide proven techniques for winning cooperation, encouraging responsibility, and understanding more about young children's behavior.

Figure 5–2. Sample child care workshop advertisement. Copyright© Maryland Committee for Children, Inc. Reprinted by permission.

programs, target services to children who may be at risk of failure because of their socioeconomic environments.

While some states have expanded programs and services for young children to meet the comprehensive needs of children and their families, others have been slow to adapt to changes in the needs of families. Many children may need full-day child care *and* the stimulating environment of programs such as Head Start. However, in many areas there is a shortage of affordable school-age child care, and working parents often cannot make arrangements to safely transport their young children from part-time programs to child care providers.

All over the United States, diverse groups are working together in cooperative and collaborative efforts to provide services that meet the comprehensive needs of children and their families. Child care resource centers play an important role as advocates for the child care community and the other shareholders in the child care delivery system.

Legislation at the federal and state levels continues to promote greater interagency involvement in meeting the diverse needs of children. Collaboration among public and private community agencies and providers is being encouraged through funding incentives of programs such as the federal Child Care and Development Block Grant. (See Chapter 8.)

In addition, the child care delivery system is directly affected by recent welfare reform initiatives that require parents of young children to be in training programs or the work force. Social service and education agencies are working closely with child care providers to meet the full-day needs of this population.

Interagency cooperation also is vital to meet the needs of special populations. In most areas there is a serious lack of available, affordable, quality child care for children with special needs. Developmentally appropriate services beginning at the earliest possible age are important to disabled children and their parents. Child care can serve as a meaningful adjunct to early intervention for these children and provide an alternative to placement in residential institutions (Maryland Committee for Children, Inc., 1989).

Finally, child care can no longer be viewed as a short-term problem for some working parents. Child care services are critically important in maintaining the economic vitality and growth of a region. As noted earlier, shareholders in the child care delivery system include not only parents and providers, but also employers, unions, governments, and other agencies. Solutions to ongoing

problems of providing quality child care that is available and affordable must come from both the private and government sectors.

INCREASING THE SUPPLY

One of the functions of a CCRC is to analyze the supply of child care, compare supply to demand for service, and identify gaps in the delivery system. Once gaps are identified, targeted resource development activities can be undertaken to stimulate the supply of child care providers. These efforts can take the form of technical assistance services to help providers in starting or operating child care programs or to encourage businesses and other groups in developing responsive workplace and family policies or programs. Technical assistance can range from updates on liability issues to information on the latest in marketing trends. Technical assistance encompasses a standard core of services, including:

- Developing publicity and community outreach campaigns to recruit people interested in providing family day care or operating centers;
- Providing point of entry information, training, and referrals for potential and existing providers about the regulatory system;
- Identifying barriers to expansion and retention and helping launch public policy initiatives to eliminate these barriers;
- Serving as a catalyst for development of special technical initiatives for the child care field (such as child care for teenage parents);
- Educating people about child care delivery and expansion, employer-sponsored options, and work/family issues; and
- Providing technical assistance to employers that establish workplace initiatives. (TECHNIC, 1992)

Technical assistance serves diverse clients, including employers, existing and potential providers, Head Start programs, nursery school, co-ops, drop-in centers, play groups, community nonprofit organizations, and public agencies. Figure 5–3 is a typical promotion for employers.

Services are usually delivered through telephone consultation and referrals, seminars and workshops, individual and group client consultations, individual contract, on-site visits, publications and handouts. Many CCRCs offer a core level of free

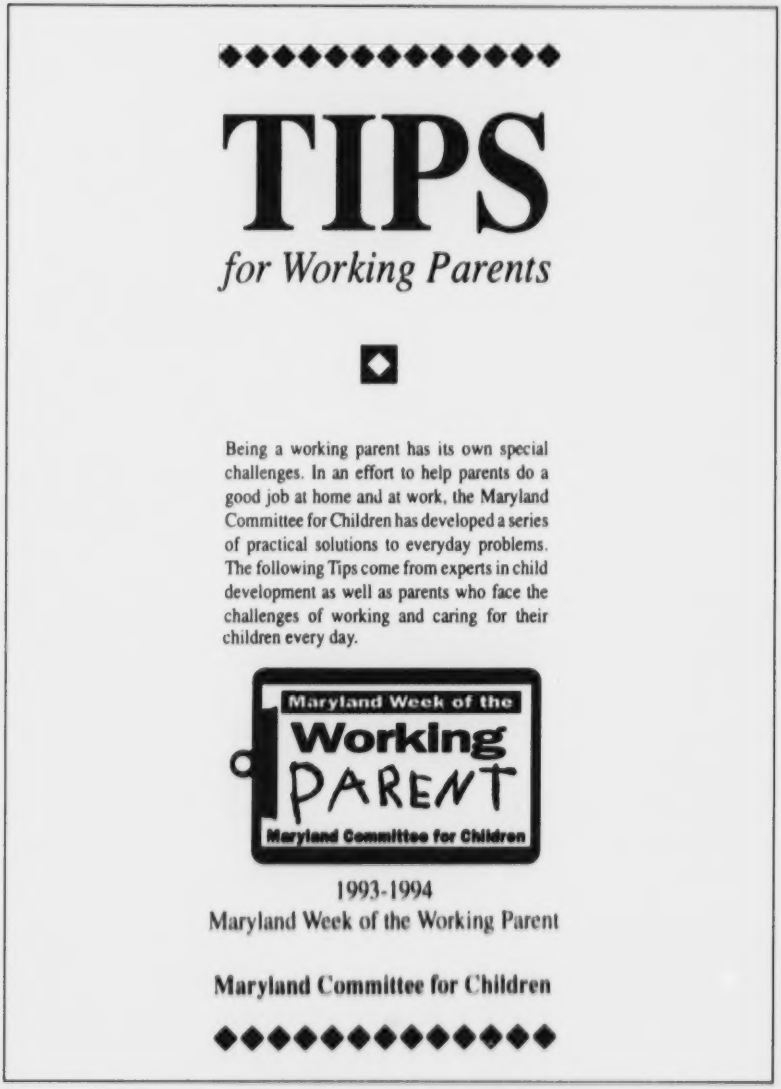

TIPS
for Working Parents
Being a working parent has its own special challenges. In an effort to help parents do a good job at home and at work, the Maryland Committee for Children has developed a series of practical solutions to everyday problems. The following Tips come from experts in child development as well as parents who face the challenges of working and caring for their children every day.
Maryland Week of the
Working
PARENT
Maryland Committee for Children
1993-1994
Maryland Week of the Working Parent
Maryland Committee for Children

Figure 5–3. Typical promotion made available through employers. Copyright© Maryland Committee for Children, Inc. Reprinted by permission.

services to clients, charge a nominal amount for more formal training, and provide in-depth services on a contractual basis.

Work and Family Issues

While most technical assistance is aimed at existing and potential child care providers, CCRCs are also involved in education and advocacy projects. An important function of the CCRC is increasing the role of the business community in child care. Businesses can help employees with child care through several options, from providing on-site child care to offering enhanced resource and referral services. Some companies may offer child care as part of their benefits package, while others help employees take advantage of programs that allow child care costs to be paid with pre-tax dollars.

Another function of technical assistance is gathering and supplying statistical and anecdotal information regarding barriers to child care expansion and retention to policy makers. These services are available to all community agencies, organizations, and volunteer groups involved in these issues (TECHNIC, 1992).

Operating Child Care Programs

The philosophy of technical assistance for providers is based on the "enabler" model. This model uses principles of community organizing and small business assistance that help people acquire the technical knowledge and tools to start and maintain child care businesses. "The goal is to teach people how to fish, not to do the fishing for them" (TECHNIC, 1992, p. 3-1).

Clients are given a core set of materials and information, including:

- All legal and business aspects of operating programs;
- Local and state regulatory climates, procedures and requirements;
- Child care supply and demand, delivery systems, networks and resources; and
- The pros and cons of entering the child care field. (TECHNIC, 1992, p. 9-3)

Follow-up procedures are used to track the progress of potential providers. While technical assistance staff are not regulatory agents, they do play an "ombudsman" or assisting role by guiding providers through bottlenecks in the regulatory process. Although certain information is helpful for all kinds of child care providers, specific technical assistance is offered for family day care providers and for center operators.

Family Day Care Assistance

Family day care homes are residences where care is given in the provider's own home for less than 24 hours a day (Horovitz, 1980). Many states require providers to be licensed if they care for children who are not related to them, they are paid for this service, and the care is on a regular basis. Licensing allows providers to:

- Obtain liability insurance,
- Legally claim tax deductions for the business use of the residence;
- Be listed with the local child care resource and referral agency;
- Legally advertise in local newspapers; and
- Be eligible for training and other services offered by regulatory agencies and the CCRC.

The first step for most providers is learning about the regulatory process. Many states have rewritten or adopted new regulations in the past 10 years to create healthier, safer environments for children. Technical assistance counselors help providers understand and comply with all requirements in state and local regulations.

Counselors also help providers comply with requirements of other agencies, including building inspection, zoning, and fire departments. Information about Social Security, federal tax deductions, liability insurance, among other topics is also provided. In addition, the CCRC offers training to help providers design developmentally appropriate activities for children in their care.

Child Care Centers

Starting a child care center is a more involved process that requires careful planning and attention to detail (The Day Care Council of America, Inc., 1981). A different set of regulations set specific requirements for every aspect of operation, including inside and outdoor space, staff-to-child ratios, training and experience of staff, activities, and parent involvement.

Almost all centers must be licensed to operate in the United States. (Some states exclude child care centers operated by religious organizations.) The licensing process usually includes not only requirements specified in the regulations, but also inspections for fire, zoning, health, building, and sanitation codes.

Centers are separated into two basic categories: profit and not-for-profit. The main difference between the two types of centers is determined by how surplus money is spent after all

expenses are paid. For-profit organizations keep surplus money for the owners, paid as dividends, or put it back into the operation of the business. Earnings also are subject to taxation. Money left after expenses in a nonprofit organization must be returned into the operation of the center. These businesses are also eligible for tax-exempt status (The Day Care Council of America, Inc., 1981).

The main start-up costs are preparing and equipping a facility for use as a child care center. Centers can be located at commercial sites, within churches or schools, in public or privately owned buildings, or be freestanding. Most sites that already exist must be renovated to meet licensing requirements. Technical assistance through a CCRC often is critical during the start-up phase, especially for proprietors of smaller centers.

Activities for children at centers usually are more structured than those in family day care homes. Program directors usually are required to have college-level training and experience in early childhood education and development. Continuing education for center staff often is provided through the CCRC. Courses are designed to help staff understand the developmental needs of children and are offered at reasonable cost and at convenient times.

FUNDING

Parents provide almost all of the funding for child care. However, an increasing amount of outside funding has become available for both providers and families in the past few years. (See Chapter 8.)

Resources for Providers

One of the hardest tasks facing potential child care providers is finding outside funding to start up a center or family day care home. Public funding is seldom available, but there are sources for loans and grants depending on whether the organization is for profit or not-for-profit (The Day Care Council of America, Inc., 1981). Some states and communities now offer low-interest loans for both family day care providers and center operators. Local child care resource centers provide technical assistance about funding sources through seminars and consultation.

One potential funding source is the Small Business Administration. This federal agency loans money to help people start small businesses such as family day care homes. If the business is 51 percent owned and operated by women, providers may be eligible for a special Mini-Loan Program for Women.

Loans or grants also may be obtained from businesses in return for discounted fees for employees. Companies may provide financial support by contributing seed money for initial construction or renovation of a center or sharing part of the operating costs (Guidelines, 1990).

Some states and communities also fund scholarships for providers for continuing education or for early childhood courses leading toward a degree or certification. Recipients usually are required to work in the child care field for a specified amount of time. Information about scholarships is available through regulatory agencies or community CCRCs.

Resources for Families

Families can get help with child care costs from both the private and public sectors. Most states, through local social service agencies, provide child care assistance for low-income families through vouchers or provider reimbursement. Many of the recent welfare-to-work initiatives funded by states or the federal government also provide not only child care funding but enhanced resource and referral services through local CCRCs.

Another source of public funding of child care for families is the federal Child Care Income Tax Credit. The amount of the tax credit is determined by the family's income and is subtracted from the amount owed for federal income tax.

In the private sector, businesses are becoming a more active partner in the child care delivery system. Businesses support employees with children by:

- Providing enhanced resource and referral services that counsel employees on how to locate and evaluate quality child care, enabling them to make better decisions;
- Subsidizing a percentage of the child care costs at a program selected by the parent, paying the providers directly or reimbursing the employee;
- Negotiating with child care providers to create discounts for employees;
- Allowing employees to take advantage of the Dependent Care Assistance Program under the Internal Revenue Service, whereby employees can pay for dependent care with pre-tax dollars; and
- Setting up alternative work schedules to allow employees better use of work and personal time (Guidelines, 1990).

Private funding may also be available through church-affiliated grants and scholarships. This funding is designed to help church members or members of the community pay for child care, based on need and number of children in a family. In addition, non-profit organizations often have programs to assist members of the community with financing child care.

The best place for families to begin looking for public and private assistance is the local child care resource center. Counselors at the CCRC can provide information about different programs and eligibility requirements.

Meeting the need for child care is not a simple task. Finding the balance between the cost of child care, the salaries of child care workers, and the elements which result in quality care poses a major challenge to all those who rely on the availability of such care. The role of child care resource centers is to encourage all of the shareholders in child care—parents, employers, providers, government, labor, advocates and community groups—to work together to develop solutions that strengthen child care delivery.

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CHAPTER 6

TRAINED PROVIDERS AND QUALITY CURRICULUM

CHRISTINA MANDELSON

The growing need and demand for child care, coupled with rising public awareness of and concern over the quality of care, have focused attention on the need for "nurturing, trained, and stable" providers who have opportunities "to interact with . . . children and with whom . . . children can develop positive attachments" (Children's Defense Fund, 1991, p. 38). It has been well documented in the literature that the training of child care providers is essential to high-quality child care. The National Day Care Study (Ruopp, Travers, Glantz, & Coelen, 1979) reported that "caregivers with education/training relevant to young children deliver better care with somewhat superior developmental effects for children" (p. 3). In 1987, Schweinhart, Koshel, and Bridgman found that "only one teacher characteristic predicts program quality and effectiveness: the amount of job-related training in early childhood education that a teacher has received" (p. 527). Gotts (1988) further supports these findings by reporting that of all the essential elements in developing and maintaining quality programs, the most important staff characteristic is the combined training in early childhood education and child development.

The quality of child care has long-lasting effects on children's future development. Studies show that children who have

experienced quality child care are "less likely to have behavior problems and are more likely to develop good social and academic skills" (Children's Defense Fund, 1991, p. 38). According to the Child Care Action Campaign (undated), the formal or informal training of child care providers in early childhood education and child development have a direct effect on whether the experience is positive or negative for the children involved.

The TASK (Training Approaches for Skills and Knowledge) Project of the National Center for Clinical Infant Programs (NCCIP) concluded that all individuals who work with and provide services for infants and young children "need specialized knowledge and skills to address the unique developmental needs of (these) children and (their) parents," and that regardless of program setting, "specialized training is proving critical to the performance of staff and to improved developmental outcomes for infants" and young children (Fenichel & Eggbeer, 1990, p. 1). Table 6–1 highlights the TASK approach. The project further reports that, in 1989, the National Child Care Staffing Study found that the amount of formal training a teacher achieved "was the strongest predictor of appropriate teacher behavior, with specialized training emerging as an additional predictor in infant classrooms" (Fenichel & Eggbeer, 1990, p.4). Experience alone was not found to be a predictor of teacher behavior.

The National Association for the Education of Young Children (NAEYC) states in their position statement that "a major determinant of program quality is the extent to which knowledge of child development is applied in program practices—the degree to which the program is *developmentally appropriate*" (Bredekamp 1987, p. 3). The concept of developmental appropriateness, or developmentally appropriate practice (DAP), incorporates two aspects: age appropriateness and individualization. Position statements on the need for provider knowledge of child development from other professional organizations concur

Table 6–1. *Highlights of the TASK Approach*

Training Approaches for Skills and Knowledge (TASK)
All individuals working with and providing services for infants and young children "need specialized knowledge and skills to address the unique developmental needs of (these) children and (their) parents."
A PROJECT OF THE NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS NCCIP

with NAEYC and consistently mandate the knowledge of child development as a requisite for teaching and providing child care (Association for Childhood Education International, Gotts, 1988; National Association of State Boards of Education, 1988; National Association for the Education of Young Children & National Association of Early Childhood Specialists in State Departments of Education, 1991).

STATE TRAINING REQUIREMENTS

The regulation of training and education is one method of ensuring an adequate and appropriate child development knowledge base in early childhood programs. Regulation, however, is presently state mandated, and requirements for early childhood teachers and directors in nonpublic school programs vary widely from state to state. Twenty-six states do not require pre-service training or experience for nonpublic school teachers; however, all do require ongoing training once employed (Kuykendall, 1990).

Director training requirements for nonpublic school programs also differ widely among the states. Only 18 states require "some college or other training plus experience," and of that training, child development and appropriate practices may or may not be included (Kuykendall, 1990, p. 49). These statistics are particularly alarming given the general consensus among professional organizations and academic experts that training and education help to ensure high-quality early childhood programs. High-quality early childhood programs provide a safe, healthy, and nurturing environment, promoting "the physical, social, emotional, and cognitive development of young children while responding to the needs of families" (Bredekamp, 1987, p. 1). Schweinhart, Koshel, and Bridgman (1987) concur and state that if early childhood programs are to be high-quality, promoting the principles of DAP, they must "be administered by competent specialists in child development who can establish an environment that supports active learning" (p. 527). Training and education, provided on a regular and continuous basis, are a means to achieving high-quality child care in all program settings.

Nonpublic and public school teachers look to their directors and other administrative personnel for guidance and support in making quality program decisions that are developmentally appropriate for the program as well as for each individual child. Thus, a solid knowledge base in child development is necessary

for both teachers and administrative personnel in all early childhood program settings to ensure appropriate program practices and policies. Training and education in child development and DAP are key elements to promoting and providing high-quality child care programs and should be a requisite for all teaching and administrative positions.

WHO ARE THE TRAINED PROVIDERS?

There are many levels of trained providers in the early childhood profession, serving in a variety of program settings. An early childhood program is defined as "any part-day or full-day group program in a center, school, or other facility that serves children from birth through age 8" (Bredekamp, 1987, p. 1). These settings include child care centers, infant centers, family child care homes, private and public preschools, pre-k programs, kindergartens, and primary grade schools (first through third grades). There are a variety of training and education requirements from setting to setting. Some settings require a Child Development Associate Credential (CDA), or an associate (2-year) or a baccalaureate (4-year) degree; others require more informal training in child development and DAP through workshops and seminars. Trained providers are varied in background and training and include those listed in Table 6–2. Trained providers employed in these settings may be teachers who are responsible for the care and education of a group of children (Bredekamp & Willer, 1992), teacher assistants and educational aides, directors and other administrative personnel, and, with the increased inclusion of children with special needs in response to the Individuals With Disabilities Education Act (IDEA) and the Americans With Disabilities Act (ADA), early intervention personnel.

Table 6–2. *Samples of Trained Providers*

Who Are the Trained Providers?
teachers
teacher assistants
educational aides
directors
administrative personnel
early intervention personnel

TYPES OF TRAINING

Knowledge is constructed through various forms of education and training. There is formal education such as courses taken at a college, university, or community college, which can lead to a baccalaureate degree (BA or BS) or an Associate in Arts (AA) degree. There are also formal training programs such as the Child Development Associate (CDA), which can lead to CDA assessment and credentialing. This competency-based program requires individuals to satisfactorily demonstrate skills acquired in six core competency goals. The CDA Credential can be awarded to individuals who may be involved in other types of formal training or to those who may be informally trained through workshops and seminars by applying to the Council for Early Childhood Professional Recognition and successfully completing the assessment process. (The six competency goals are discussed in more detail later in this chapter.)

Workshops, Seminars, and Conferences

There is the less formal, but equally important, training through workshops, seminars, and conferences. This type of training provides avenues for in-service and continued training for all levels of trained providers. Given the importance of a well trained staff, as presented in the beginning of this chapter, directors and administrators should plan an effective and meaningful in-service training program for their staff as well as for themselves. The first step in the planning process is the identification of training needs, or a needs assessment. Training needs can be identified through several strategies: observation, needs assessment surveys, program evaluation measures, and staff and parent evaluation measures (Abbott-Shim, 1990). Assessment is a continuous process, as training needs change over time; there are always new challenges, new research findings, and new ideas on methodology. In-service training is an enrichment program with the fundamental purpose of enhancing providers' skills and expanding their knowledge base in early childhood education and child development (Sciarra & Dorsey, 1979).

On-the-Job Training

Another, more informal training strategy is on-the-job training. Although often used interchangeably, in-service and on-the-job

training are slightly different methods. As previously noted, in-service is an enrichment program whereas on-the-job training "implies hiring untrained staff members and providing actual job training opportunities while the staff member is employed" (Sciarra & Dorsey, 1979, p. 349). The actual training is an organized, comprehensive system of instruction, including basic hands-on learning experiences, through regularly scheduled classes or meetings. Oftentimes, directors and administrators do not have the time or resources to provide extensive on-the-job training but will use budgeted training money to send providers-in-training to college, postgraduate programs, or CDA training. This, of course, depends on the program's financial resources and the ability to schedule release time for the employee.

Continuing Education

Providers may wish to continue their education beyond their degree or certification. Continuing education courses, offered in colleges, universities, and community colleges, for credit and noncredit, can provide the opportunity to do so. Professional organizations often collaborate with a college or university when sponsoring conferences and are able to offer continuing education credits (ceu's). Oftentimes, providers find it economically necessary and intellectually beneficial to obtain on-the-job experience for a period of time before enrolling in advanced academic study.

Whether a provider's *pre*-service training and education are achieved through formal or informal strategies, or a combination of both methods, *in*-service and continuing education are essential. The TASK Project concluded that "training is a lifelong proposition for practitioners" working with infants and young children (Fenichel & Eggbeer, 1990, p. 1). (A practitioner, as used here, includes health and education professionals, child care providers, community volunteers, and parents.) The project further reports that to become and remain competent, trained providers in the early childhood profession (and in other professions, such as early intervention personnel, involved with infants and young children and their families) "need up-to-date preservice preparation, meaningful in-service training, and high quality continuing education opportunities" (Fenichel & Eggbeer, 1990, p. 1). It is interesting to note the project's definition of a competent practitioner: "Competence can be defined as the ability to do the right thing, at the right time, for the right reasons" (Fenichel & Eggbeer, 1990, p. 5). In practice, competence is the involve-

ment of having the capability to analyze a situation; consider possible approaches; select and skillfully apply the best strategy, or strategies, possible; accurately evaluate the outcome(s); and explain each step of the process, that is, demonstrate knowledge, skill, understanding, and accountability (Fenichel & Eggbeer, 1990). In sum, competency is the outcome of combined knowledge, skills, and experience.

DETERMINING COMPETENCE

Competence can not be determined through academic course work or other training methods alone, it must be demonstrated. To this end, the use of supervision and mentorship are essential components to training and education and to actual on-the-job practice. Fenichel and the NCCIP Work Group on Supervision and Mentoring (1991) reported that "experienced administrators and providers agreed on the essential features of effective supervision and mentoring—reflection, collaboration, and regularity" (p. 2). Reflection is defined as a "continuing conceptualization of what one is observing and doing" (p. 5). As supervisors and mentors become more aware of and better able to conceptualize their own roles, the better they will be able to assist their protégés in identifying and understanding child development and developmentally appropriate practices, and to apply these principles in their programs. They can direct providers to current methods and materials and can demonstrate, or even role play, specific techniques (Feninchel & NCCIP Work Group on Supervision and Mentorship, 1991). Supervisors and mentors can help protégés develop and refine their observation skills with young children and their families and, in turn, use these skills to provide an appropriate, responsive and reflective program.

Supervision

There are three elements necessary to establish effective supervisory and mentoring collaborative relationships: power, mutual expectations, and communication (Fenichel & NCCIP Work Group on Supervision and Mentorship, 1991). In a collaborative relationship, power is mutually shared, although not always equally shared. Examples of power shared, although unequally, are (1) supervisors of student teachers responsible for evaluating the student's ability to integrate learned knowledge and skills

and to demonstrate competency and (2) supervisors in the workplace responsible for employees' evaluations on the quality of their job performance and demonstrated knowledge and skills.

"Clear mutual expectations seem to be critical to the success of a collaborative supervisory or mentoring relationship" (Fenichel & NCCIP Work Group on Supervision and Mentorship, 1991, p. 6). The boundaries, responsibilities, and expectations need to be identified and clearly defined, preferably in a written document, of each person in the relationship. There must be an agreement on the logistics, that is, the "how often" and the "when and where" meetings will take place. There must also be an agreement on the content of the supervision and the evaluation methods used.

Within supervision and mentorship, communication should flow freely (Fenichel & NCCIP Work Group on Supervision and Mentorship, 1991, p. 7). Open communication between supervisor and supervisee is an essential component to this training method. It serves as a model for establishing and maintaining relationships between providers and peers and co-workers; between providers and other professionals; between providers and the families they serve; and, ultimately, between parents and children.

Finally, supervision and mentorship must be done regularly to be an effective training and education tool. Time must be identified and scheduled for the development and growth of these relationships, and this time must be guarded and adhered to. "It takes time to reflect, time to collaborate, and above all time to establish trust in the reliable nature of the relationship itself" (Fenichel & NCCIP Work Group on Supervision and Mentorship, 1991, p. 7).

THE NEED FOR SPECIALIZED EARLY CHILDHOOD TEACHER CERTIFICATION

Given the diversity of training and the various levels of education achieved by providers in the early childhood profession, one may wonder what common threads exist, or should exist, throughout all types of early childhood training and education. The similarities lie in the common core of shared knowledge and skills related to child development and DAP which is how early childhood is defined as a profession. Bredekamp and Willer (1992) state that "having a specialized body of knowledge that is shared by all members is one of the distinguishing characteristics of a profession" (p. 48).

A position statement on early childhood teacher certification by the Association of Teacher Educators (ATE), through its

Commission on Early Childhood Teacher Education, and NAEYC (1991) recommends the establishment of specialized early childhood teacher certification standards for all levels of teachers working with infants and young children, birth through age eight. Furthermore, the statement recommends that this certification "be developed exclusively for early childhood education and be distinctive from, and independent of, existing elementary and secondary certifications" (Association of Teacher Educators and National Association for the Education of Young Children, 1991, p. 17). Ultimately, this certification would establish a national minimum standard for a mandatory, state-level process whereby a person meeting the requirements would be granted a license or permit to practice in any early childhood program, regardless of setting, within the state. These certification standards would also be the measure by which an institution is approved by the state to grant early childhood teaching certificates.

The need for a specialized early childhood teacher certification becomes even more apparent when one reflects on the fact that there are variant levels of teacher training and education, depending on where the teacher is employed. However, the basic needs of infants, toddlers, preschoolers, or primary grade school children do not change from one setting to another. Whether 4-year-olds attend public or private school kindergartens, child care centers, family child care homes or Head Start programs, their basic needs remain the same. Early childhood teachers, in all settings, need to be trained and educated in providing the appropriate environment, experiences, attitudes, and expectations for the children in their programs.

Early childhood is not the only profession that should require specialized training and education for children, birth through age 8, and their families. Training addresses several purposes, as shown in Table 6–3.

All individuals who work with and provide services for this age group and their families need specialized instruction, including direct, hands-on experiences, to integrate knowledge and skills into practice and to demonstrate competency. With the passage of Individuals with Disabilities Education Act (IDEA) and American Disabilities Act (ADA) and the recent growth in services for infants, toddlers, and preschoolers and their families, state agencies, professional organizations, and college/university programs need to develop meaningful standards and relevant education programs, reflecting the specialized knowledge and skills needed to prepare early intervention (EI) person-

Table 6–3. *Training Purposes*

Specialized Instruction
direct, hands-on experiences, in order to integrate knowledge and skills to demonstrate competency.

nel to work effectively and positively with infants, toddlers, and preschoolers and their families (Bailey, Simeonsson, Yoder, & Huntington, 1990). EI personnel is a collective term and is best described as a culmination of several disciplines including special education, social work, occupational and physical therapy, speech and language pathology, nursing, and nutrition. Training programs must not only enable these personnel "to acquire the knowledge and skills of their own discipline" but also to "adapt them to the specific requirements of working with infants, toddlers, (preschoolers, and primary school-age children), and their families" (Fenichel & Eggbeer, 1990, p. 1).

FAMILY CENTERED CARE

In October 1986, Public Law (PL) 99-457 was passed by congress as an amendment to the Education of the Handicapped Act. Part H of this law ensures eligibility for infants and toddlers with disabilities (birth through age two) and their families to receive early intervention services. In October 1991, PL 102-119 reauthorized Part H and changed the name of the act to the Individuals With Disabilities Education Act, IDEA. Part H of IDEA establishes the framework for a comprehensive, coordinated, family centered, community-based, interagency, and multidisciplinary delivery system of care to infants and toddlers with disabilities and their families. A family centered approach acknowledges and respects the family as the constant in the child's life, while early intervention systems, and personnel within those systems, fluctuate (Association for the Care of Children's Health, 1990).

While it is important for EI personnel to incorporate family centered practices into their systems of care, it is also important for all early childhood providers to incorporate this philosophy into their programs. The family is the constant in a child's life whether the child has, or does not have, disabilities. Parent involvement and family support are essential elements of all

early childhood programs. It is important to note here that there are various family constellations. *PROJECT TOGETHER: Partnerships Among Parents, Providers and Professionals* broadly defines the family as "a configuration of adults and children that live together and share responsibility for each other" (Mandelson, 1992, *PROJECT TOGETHER: Partnerships Among Parents, Providers and Professionals*, Unit 1, Module B, p .2). These constellations may include two parents and one or more children; a single parent and children; grandparents caring for grandchildren; foster families; and adoptive families.

In 1991, Association of Teacher Educators (ATE) and National Association for the Education of Young Children (NAEYC), in their position statement on early childhood teacher certification, identified family and community relations as a certification standard for teachers of children from birth through 8 years. Specifically, the statement reports that early childhood teachers should be able to convey information and insight to families on such issues as: child development and DAP; developmentally delayed and early intervention services, including available EI and special education community services for the young child and their families; the interconnectedness that occurs in relationships between parents and child, child and siblings, child and extended family members, and child and community; and the roles of parents as primary caregivers and initial, informal teachers of young children who are the constant in the child's life. These standards stress the early childhood educator's ability to collaborate and cooperate with the family as well as with community systems "in an effort to build upon the child's sociocultural background," and with the support of EI personnel, to work with families that have children with disabilities (ATE & NAEYC, 1991, p. 19).

Partnerships between program staff and families encourage open communication and mutual support that builds understanding and guidance, and provides greater consistency for children (Bredekamp, 1987). Consistency is essential in the lives of young children; they depend on it to make their environments stable, supportive, orderly, and predicable. For this reason, it is especially important for families and providers to discuss values and attitudes in childrearing practices. Children can become confused, anxious, nervous, frustrated, and angry without the continuity between what is expected at home and in the program environment.

Early childhood programs should be reflective of the cultures present in the communities they serve. Program personnel must

be aware of and sensitive to these cultures. For this reason, early childhood training and education programs should include sessions and courses on cultural sensitivity and competence, promoting the understanding of and respect for cultures differing from their own as well as individual variations within these cultures. In sum, the ability to collaborate and support families and to enhance and support their childrearing practices "demands an understanding and respect for cultural and familial diversity" (ATE & NAEYC, 1991, p. 18).

TRAINING CONTENT: EARLY CHILDHOOD SPECIALIZED KNOWLEDGE AND SKILLS

As previously discussed, ATE and NAEYC (1991) recommend the establishment of specialized early childhood teacher certification standards for all levels of teachers, regardless of program setting. This recommendation is further supported by other professional organizations such as the Association for Childhood International (Gotts, 1988), the Association for Supervision and Curriculum Development (Wagner, 1988), and the National Association of State Boards of Education (1988). To establish certification standards, a common core of knowledge and skills must be identified and incorporated into all early childhood education and training programs. Bredekamp and Willer (1992) identified these basic components of knowledge and skills when they examined the requirements for early childhood professional preparation programs resulting in the acquisition of a CDA Credential, an associate degree, a baccalaureate degree, or an advanced degree in Early Childhood Education. Furthermore, the researchers report that progressive levels of education and training should expand on this common core of knowledge and skills "in both breadth and depth through increasing levels of preparation as well as in areas of specialization" (Bredekamp & Willer, 1992, p. 49).

The identified common core of knowledge and skills necessary to enable early childhood professionals to provide high-quality, developmentally appropriate programs, regardless of role, job setting, level of training or education, or the age range of children served, are:

- to demonstrate a broad, basic understanding of child development, birth through age eight;
- to develop and maintain a safe and healthy learning environment for young children;

- to plan and implement developmentally appropriate activities that enhance and encourage growth in all areas of children's development and learning, including intellectual, social, emotional, physical competence;
- to establish positive, supportive relationships with children and implement developmentally appropriate guidance and individual and group management techniques;
- to establish collaborative, supportive, and productive relationships with families;
- to support and respect the uniqueness of each child, recognizing that they must be understood in the context of their families, communities, cultures, and society; and
- to demonstrate an understanding of the early childhood profession and to maintain a commitment to professionalism. (Bredekamp et al., 1992, p. 49).

Not surprisingly, these seven aspects are consistent with the six core competency goals for the CDA Credential. The Council for Early Childhood Professional Recognition (1990) identifies the CDA competency goals as the ability to "establish and maintain a safe, healthy learning environment; advance physical and intellectual competence; support social and emotional development and provide positive guidance; establish positive and productive relationships with families; ensure a well-run purposeful program responsive to participant needs; maintain a commitment to professionalism" (p. 2). During the assessment process, an individual is required to demonstrate the acquisition of these skills and knowledge and the ability to successfully implement them into practice.

All education and training endeavors, including colleges/universities and specific training programs, should strive to reflect these core concepts as a basis for their instruction. As providers elect to specialize within the early childhood profession, specialized knowledge is required and should be built upon the profession's core content of knowledge and skills. For example, a family child care provider needs to know aspects of operating a small business whereas a classroom or center-based teacher would not. Other areas of required specialized instruction include resource and referral roles, program administration, teacher general and special education.

Early childhood professional preparation guidelines are intrinsically general, as they are for all professions, and "must be translated into specific curricula" (Bredekamp & Willer, 1992, p. 49). Identifying the specifics is an ongoing process as new

research findings continually change and expand the understanding of the complexities of early development. These findings, coupled with the expanding and changing needs of children, families, and communities, help to expand and change the knowledge base of child development. Education and training programs have the responsibility to address current research findings, new challenges, and relevant concerns reflected in our society. Some of the issues that need to be addressed more effectively are the inclusion of children with special needs into all programs; cooperation and collaboration with families and communities, and across all professions involved with young children and their families; individual family and cultural diversity; children who are drug exposed prenatally or who are drug affected environmentally; children with HIV infection; children with fetal alcohol syndrome (FAS) or fetal alcohol effect (FAE); advocacy and public policy issues; program curriculum and assessment; and providing care for infants and toddlers (Bredekamp & Willer, 1992).

NATURAL ENVIRONMENT AND TRAINING

As previously discussed, training and education in child development and developmentally appropriate practices are not limited to the early childhood profession. All EI personnel working with young children, birth through age eight, and their families also need specialized training in early childhood development and DAP. IDEA specifies intervention services to be performed in the "natural environment" for children and families. This may be in the home, child care center, family child care home, infant center, and so on. Children develop within the context of their environments, that is, home and child care program, if attended. Early intervention services should be delivered in harmony with the natural environment for the child and family. Noonan and McCormick (1992) report that currently, "best practices," or strategies, in early intervention, refer to "the child, family, peers, and community" and that these practices are to be "individualized and responsive" (p. 148) which is consistent with DAP's principle components, age appropriateness, and individualization. Newly acquired skills are relevant and easily applied to the child's and family's routines when taught within the natural environment. Furthermore, interventions delivered in the natural setting tend to focus on the "immediate needs" and addresses the "critical characteristics of the situation in which the skill

must be demonstrated" (Noonan & McCormick, 1992, p. 148). Moreover, intervention should target functional skills that have relevance for present and future use.

In sum, all individuals providing care, education, and early intervention services to young children and their families need to acquire specific knowledge and skills and demonstrate competency in early childhood education and child development to provide high-quality programs and meaningful interventions. The goal is to provide early childhood programs and early intervention services that are consistent with DAP, that is, to be age appropriate and individually appropriate, for all young children, including those with special needs. Essentially, the means to this end is through provider training and education in child development and developmentally appropriate practices.

SUMMARY

The role of the early childhood provider is not to "watch" our children; the role is to provide developmentally appropriate care, education, and guidance for them in high-quality early childhood programs. Research findings consistently report that training in early childhood education and child development are essential elements to program quality and effectiveness. To provide high-quality programs and the most meaningful early interventions possible, all levels of trained and educated providers need to acquire a common core of early childhood knowledge and skills and demonstrated competency. This core content of information is expanded and broadened with continued training and education. Areas of specialization require specialized knowledge that should be built on the profession's core content of knowledge and skills. All children and families deserve, and moreover, have the right to high-quality, developmentally appropriate programs. As Kuykendall (1990) so perfectly stated, "Child development is so important, children shouldn't be enrolled in programs without it" (p. 50).

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CHAPTER 7

PROMISING PRACTICES IN PROGRAMMING

I. Programming for Children Who Are HIV+ or Exposed to Substance Abuse

CLARE SIEGEL

There are no accurate estimates of the number of children in child care settings who are infected with Human Immunodeficiency Virus (HIV) or who have been exposed to substance abuse. It is known though that the numbers are growing in direct proportion to the increase in drug use and HIV infection in at risk women. All child care providers need to be aware of several issues in serving these populations and should assume that any children in their care may already have these conditions. Understanding the facts will assist providers in better caring for children infected with HIV and/or those who have been exposed to substance abuse.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

Medical research continues to confirm that the HIV/AIDS virus is not transmitted through casual contact. The Centers for Disease

Control (CDC) recommend that children and staff not be excluded from child care programs solely on the basis of their HIV/AIDS diagnosis (American Academy of Pediatrics, 1988). To feel comfortable with these two statements, providers need to have some basic information on HIV/AIDS.

AIDS is a medical condition indicating progressive, currently irreparable, deficiencies in the body's immune system secondary to infection with HIV. The immune system is that body system responsible for resisting infection. HIV replicates itself in body cells and particularly attacks the T cells within the immune system and causing it to break down (Santelli & Birn, 1991). It takes years for AIDS to develop in most children and adults. Symptoms and degree of illness vary from person to person, depending on HIV virulence or other as yet undefined host factors in the body.

TRANSMISSION

Transmission of HIV occurs along several routes: through infected semen or vaginal fluids during anal, vaginal, or oral sexual intercourse; and through infected blood during blood-to-blood contact, such as sharing needles; or from mother to fetus across the placenta, or during childbirth; or through breast feeding (Santelli & Birn, 1991). Young children in child care who are infected with HIV are most likely to have been infected maternally. The likelihood of transmission from mother to unborn child is approximately 20 to 25 percent (University of MD, 1993). In rare cases, breast milk from an infected mother may transmit HIV to an infant. Though the concentration of the virus in breast milk is fairly low, it is theorized that the infant swallows large volumes over a relatively short period of time. Cracked nipples may also allow the ingestion of the HIV infected mother's blood. The digestive systems of infants are immature and, therefore, may allow for easier absorption of the virus through breast feeding (Project Champ, 1991).

HIV is not transmitted through casual contact or through body fluids that do not contain blood. It is not transmitted through hugging, wiping noses, kissing, changing diapers, cleaning up vomit, or performing minor first-aid. Skin contact with HIV infected blood has only a remote chance of transmitting the virus; this increases somewhat if cuts and scratches are present. Washing the skin exposed to blood with soap and water provides excellent protection after contact (Santelli & Birn, 1991). Not everything is understood about this disease, but it is known that

the risk of contracting HIV when caring for a child with HIV is extremely low. Fortunately, HIV is not as easily transmitted as most common infections, like colds or sore throats. Therefore, it can be contained just by improving and extending basic infection control habits and practices.

THE DISEASE PROCESS

As with other chronic illnesses, HIV infection may be viewed on a continuum from the onset of infection through symptomatic periods, until death. Before the onset of symptoms of the disease, the child usually is in good health. Children who are symptomatic may feel well at times and sick at others. This roller coaster nature of HIV infection can be very difficult for caregivers, as well as the child and parents.

The time between the birth of the infant and evidence of the infection is sometimes called the indeterminate period. It is difficult to know at birth if a baby has HIV infection because of passive maternal antibody acquisition (Project Champ, 1991). Diagnosis may not be able to be confirmed until the child reaches 15 months of age, when the mother's HIV antibodies are gone.

The asymptomatic stage is the period from when the cells are infected to when symptoms occur. The length of time a child is in this stage varies. During this period it is important to keep the child as healthy as possible. This can be done by assuring adequate nutrition, practicing infection control, and seeking primary care, including dental care, and keeping immunizations up to date (Project Champ, 1991).

Children who have HIV infection need the same attention to routine immunizations as do all children, with some modifications. Killed polio vaccine is substituted for live oral polio vaccine. In the continuum of HIV disease, it is important that the child be monitored by a the doctor if exposed to chicken pox or measles. The child may need specific medications that may either protect from the infections or lessen the severity of the disease, or related complications.

SYMPTOMS

Over time, symptoms will begin to appear. Initially, these symptoms are rather nonspecific and may include those described in Table 7–1(I).

Table 7-1(I). *Developing Symptoms*

Initial Symptoms of Children Who Have HIV Infection
•failure to thrive •developmental delay (in 50% of the symptomatic children) •enlarged parotid gland, liver, spleen, and lymph nodes.

Signs of concern, if they persist or recur often, are:

- vomiting and diarrhea
- fever
- oral thrush
- Candida diaper rash
- dermatitis
- ear infections

Not all children have the same symptoms or signs at the same point in the illness continuum. Symptoms can go unnoticed or can lead to life threatening conditions. Such conditions can be managed in a variety of ways to lessen the effect on the child and family. Early intervention and preschool programs can help to foster "normal" development. Children with failure to thrive or chronic diarrhea and vomiting can follow a specific nutrition program and have their growth monitored. Medications are available to treat thrush, and good hygiene is a must. Proper skin care is necessary to clear up Candida diaper rash. Antibiotics can alleviate ear infections. Most of all, children experiencing signs of immune deficiency need to avoid people with potentially communicable diseases (Project Champ, 1991).

MEDICAL TREATMENT

Medical treatments for HIV infection may vary, but the more common include:

- Regular immunoglobulin (IVIG) given by vein to supplement the immune systems and decrease the occurrence of bacterial infections;
- AZT (ZDV), an approved antiretroviral, used to slow down the replication of HIV and improve immunological and neurological functions;

- Trimethoprim Sulfamethoxazole (Bactrim/Septra) is given to prevent a common lung infection called Pneumocystic carinii pneumonia (PCP), which can be fatal.

As the illness progresses, the more severe symptoms shown in Table 7–2(I) will appear and the child will appear quite ill.

The diagnosis of AIDS is made once the child displays these more severe diagnostic conditions. Two conditions that are rare except in children with AIDS are a pneumonia called Lymphocytic interstitial pneumonia (LIP) and PCP. PCP is one of many so-called opportunistic infections. Opportunistic infections are caused by organisms often present in the environment and usually harmless when the immune system is functioning properly (Project Champ, 1991). Because children with AIDS have compromised immune systems, the body is unable to resist the infection. These opportunistic infections in children may include severe thrush, inflammation of the back of the eye (retinitis), cold sores (herpes), and shingles. Caregivers should be aware that certain viruses such as cytomegalovirus (CMV) and herpes can be transmitted to others. The risk of the spread of these viruses to caregivers of children with HIV infection, however, is no greater than the risk in the community at large.

CARING FOR THE CHILD WITH AIDS

Once a child is diagnosed as having AIDS, the child's quality of life need not suffer. Treatment makes for variability in how the child looks and feels. Even children with AIDS, given appropriate care, can live relatively comfortable lives.

Role of the Caregiver

The kind of care given to the child infected with HIV changes as the illness progresses. For the asymptomatic child, the caregiver needs to be attentive to activities of daily living. Caregivers should

Table 7–2(I). *More Severe Symptoms*

Severe Symtpoms of HIV Infection
bacterial pneumonia
sepsis
meningitis
severe loss of nerve or brain function

practice good infection control and Universal Precautions, model good eating habits, and praise family members for what they are able to do for their child (Project Champ, 1991). The family should be informed immediately if the child is exposed to measles or chicken pox because of the potential need for specific medications and care, and the information should be conveyed to the child's regular source of medical care.

Over time, the caregiver may note subtle changes in the child's health or abilities. These changes should be communicated sensitively to the family. As the illness progresses, caregivers may need to modify the child's routine. All changes should be coordinated with the family. Caregivers need to respond by being flexible, by helping families adjust schedules, and by providing logistical support. Even when a child is ill, the basic need for love, attention, and a safe nurturing environment remains the same. This cannot be stressed too much.

Children infected with HIV may be in child care without the provider's knowledge of the child's diagnosis; therefore, careful use of Universal Precautions and infection control practices are the best approaches for all child care providers. The Centers for Disease Control and Prevention and the American Academy of Pediatrics have developed some general guidelines for dealing with the issue of children infected with HIV in child care settings (American Academy of Pediatrics, 1988). These guidelines include:

- Children infected with HIV should be admitted to child care if their health, neurologic development, behavior, and immune status allow. Most children pose no risk to others and should be placed in an unrestricted setting. The need for a restricted placement should be determined with a case-by-case review by a placement team, including the child's physician, public health personnel, the child's guardian, and child care personnel.
- Requiring screening of children for the presence of HIV on the entrance to child care is not legal under federal and state laws.
- Child care personnel should adopt routine procedures for dealing with blood spills. Hand washing and proper care in handling other body fluids are helpful in preventing the spread of both HIV and non-HIV infections that occur in child care settings.
- Parents of children in child care settings have no right to information regarding the HIV status of other children. Information about a child's immunodeficiency should be

available only to those in the child care setting who have a "need to know," so they may protect the child from other infections.

- Child care settings designed to meet the specific needs of children with HIV/AIDS may present an alternative but are not necessary for reason of infection control.

Substance Abuse and HIV

The issue of caring for children infected with HIV cannot be completely addressed without looking at the issue of exposure to illegal drugs. The majority of children infected with HIV are born to mothers who were drug abusers or had sexual contact with an HIV positive person who abused drugs.

There is much controversy about the effects on the child who was pre- and postnatally exposed to illegal drugs. The types of drugs used, amount and method of use, and timing of use are factors that contribute to the presence or absence of adverse effects on the child (Cole, Jones, & Sudofsky, 1990). Additionally, adequate research efforts to determine reliably the developmental impact of drugs is undermined by polysubstance use, poor maternal health, and lack of prenatal care. Pre-existing and ongoing effects of intergenerational family dysfunction, chemical abuse, poverty and environmental deprivation also complicate efforts to delineate the consequences of substance abuse (Cole et al., 1990).

The number of infants exposed to substance abuse is substantial and rising. A recent nationwide survey estimated that 11 percent of all newborns are exposed to illegal drugs during the prenatal and postnatal period (Gittler & McPherson, 1990). Short-term investigations of the effects of these drugs indicate that the infants are more likely to be premature, small for gestational age, more vulnerable to neonatal morbidity and to display delays in neonatal motor, interactional, and state control abilities (Schneider, Griffith, & Chasnoff, 1989). However, some research has indicated that problems resolve within several months whereas other studies have found that the effects of substance abuse continue (Crites, Fischer, McNeish-Stengel, Siegel, 1992). In contrast to children affected by HIV, no typical profile of drug-affected children has been defined.

Despite the inconclusiveness of research findings, broad trends in less formal, clinical data suggest there is a range of vulnerabilities that may result from intrauterine drug exposure. Child care providers may have drug-exposed infants who are irritable and hypersensitive to external stimulation, exhibit feeding and sleeping

problems; have tone, reflex and movement abnormalities; and produce decreased vocalizations (Weston, Ivins, Zuckerman, Jones, & Lopez, 1989). Drug-exposed toddlers often are distractible, easily overstimulated, and may exhibit delays in motor and language development and social interactions (Weston et al., 1989). Later problems also may result due to environmental factors.

SUMMARY

The needs of children who have been exposed to substance abuse or who are HIV infected vary based on the child's own unique situation. Child care providers need to be aware of this and structure the child's program accordingly, based on a developmentally appropriate curriculum and adequate medical and health practices. Programs serving these children must work in coordination with the family and respect the parents' views of the child's and family's needs.

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II. Serving the Needs of Low Incidence Children: A Local School and Community-Based Model

JUDY KANIGEL

As an administrator, working with parents and children requires flexibility and creativity in meeting their needs. The following account of my experiences may assist local community providers to address the day-long needs of children with severe disabilities.

THE BEGINNING

The phone rang in Mary Lou's office. "It's your baby-sitter." Mary Lou felt her heart pound. Yesterday, Eric's experience with the new baby-sitter had been a fiasco. Reluctantly, Mrs. Williams had agreed to watch him again. But now there was some new problem.

Eric was a handsome boy. His well proportioned body was set off by a lightly freckled face, delicate features, intense dark brown eyes, and topped with a shock of shiny, almost black hair. Mary Lou loved Eric and wanted the best for her only child. But she knew he could be a handful. Sometimes he repeated the same words or phrases over and over like a broken record. The doctor called it echolalia and said it was common in children with autistic-like behavior. And that, she knew, could be annoying. Also, Eric sometimes fixated on one child or another and picked on him or her repeatedly. One time the school sent home a note about a boy Eric had scratched several times. And yet, school was not the major problem. His teachers were trained to work with children with special needs. One of them was particu-

larly skilled in behavior management and seemed to understand Eric.

No, the real problem was child care. Someone needed to watch Eric in the morning from the time Mary Lou left for work until the bus came, and again after school until she could pick him up, about 5:30 p.m. She had been through so many child care arrangements that she had lost count. If they kept him a month she considered herself lucky. They always expected the kids they watched to sit quietly with a toy or puzzle or to play nicely with the other children. Eric could do a lot of things, but he was very active and needed someone to supervise him at all times.

Mary Lou was not surprised when Mrs. Williams explained that her health was poor and she was not able to "keep up with a child like Eric." It was just another excuse to reject her child. Her boss was understanding when she announced she would have to leave early again. Her ex-husband also was accommodating when she dropped Eric off with him the next few days. But anger welled up in her. It was unfair. She was a good mother, she worked hard, and she was a nice person. Eric was a nice person too. Why should child care be denied him simply because his needs were greater? Figure 7–1(II) illustrates what many children and parents with special needs encounter.

POLICY CHANGES

That was in 1987. In the years since, legislation has increasingly addressed the special problems of children with disabilities and their families, and child care for these special populations has become more available around the country. In Baltimore County, Maryland, for example, the county's first school-based child care center for children with special needs opened at Maiden Choice Center in September, 1988. Eric and his mother were among the first families to reap the benefits.

In 1986, a committee of parents and school staff had solicited service providers who might be willing to set up a child care program for children at Rolling Road School and its Maiden Choice Center annex. Would-be providers were interested—at first. Their initial enthusiasm soon gave way to excuses when they learned that many of these children had been rejected by other programs due to the severity of their disabilities.

The YMCA of Greater Baltimore, however, welcomed the challenge. Approached by the school committee, the YMCA was

Figure 7–1(II).

excited and wanted to become involved. The problem was where to start. At the time no formal guidelines existed for providing child care for children with special needs. Many of the licensing procedures and standards that applied to children generally would have to apply to this group of children as well; and the YMCA was familiar with these. Meanwhile, teachers and parents at the school understood the special needs of their children.

In this model, a community organization and the school were able to design a safe and productive child care setting that offered a barrier-free environment, age-appropriate activities for the children, specialized equipment and materials, trained and qualified staff, and a low staff-child ratio. Additional services, especially the staff-to-child ratio of 1:3, added to the costs. A federal Child Care and Development Block grant, however, was applied for and did cover these additional costs associated with the higher staffing and service needs, making the program affordable to parents.

FUNDING

Nationally, funding has been a significant problem in developing responsive community-based services. Subsidies for the disabled have not been offered until recently, and these supplemental stipends granted to family providers and to centers barely subsidize the increased costs of these programs (Cucci, 1991). Although funding is still limited, subsidies have been increased since then, and public officials seem to be more aware of the problem.

The biggest boost for this low incidence population came on July 26, 1990 when Congress passed the Americans with Disabilities Act (ADA). Public Law (PL) 94-142, passed in 1973, had already granted many rights and privileges to persons with disabilities related to their education. The ADA, however, will accomplish a great deal to assure access to all public facilities, specifically including nondiscriminatory requirements for child care (Surr, 1992). School programs for the disabled historically were available throughout the United States before PL 94-142. Specific handicapping conditions for which special education must be provided are identified and about 10 percent of all children are eligible for services. At the federal level, an amendment to the *Economic Opportunity Act of 1972* required that all Head Start programs had to make 10 percent of their funded slots available to children with disabilities.

CHILD CARE AND THE DISABLED

Although children with mild disabilities sometimes were accepted into child care programs, the final decision usually was left to the discretion of the individual child care provider. Often, family child care workers had limited facilities, unable to accommodate wheelchairs and other special equipment. Larger child care centers may have had the space, and even a barrier-free environment, but typically lacked experience with the disabled—and feared the unknown. The liability issues, and possible increases in insurance rates, compounded the problem.

The ADA does not mean providers must accept every child who applies for admission to a child care program. It only means each child must be *considered*, and the same rules of acceptance should apply to all children (Maze-Hsu, 1991). Providers are not required to take actions that would create an undue burden on the business, but businesses are required to do what is readily achievable. One readily achievable solution, for example, would include the following: A center accepts an 8-month-old infant

who is developmentally delayed. She has a history of breathing problems that need monitoring with special equipment and is fed through a tube inserted into a special opening in her abdomen. Although the child attends the program for only 4 hours once a week, the child care worker literally is afraid to touch her.

A medical consultant who can educate the staff needs to be available to answer questions and give professional opinions when needed. The child care workers then could feel more comfortable with this medically complicated infant, and funding problems could be minimized.

Unfortunately, all problems are not resolved so easily. In another situation a child had been attending an aftercare program at his local school for some time along with other children from the neighborhood. When he developed a back problem his doctor treated it with a brace and minor restrictions on his physical activities. The center then claimed they could no longer serve him and he was denied services.

To enforce the ADA, local, state, and federal agencies have been working on less ambiguous regulations. In Maryland, for instance, since no regulations for the disabled existed, the state permitted temporary use of a new chapter of the Code of Maryland Regulations, "Child Care Center Licensing." Two sections of these regulations describe provisions applicable to children with disabilities, the first for "Children with Special Needs," the other for "Special Care Centers (Title 7, 1991)."

These changes required that parents communicate vital health and safety information—for instance, details of tube feeding procedures—about their child to the child care provider. If special care is needed, a plan must be developed cooperatively among the parent, service provider, and any professionals that might be needed. Additional components require service providers to not only meet the same requirements governing all centers, but also to define such things as the special population to be served, the procedures to be used, and the staffing patterns and special equipment needed.

To help providers comply with existing regulations, multiple agencies need to develop step-by-step directions to ease cooperation between provider and parent. In 1992, the American Public Health Association and the American Academy of Pediatrics in the book, *Caring For Our Children*, devoted an entire chapter, National Health and Safety Performance Standards: Guidelines for Out of Home Child Care Programs, to children with special needs. In it they address, among other issues, that of mainstreaming—the concept of allowing children with special needs

to attend neighborhood programs just like everybody else. Mainstreaming, the authors make clear, is no longer just an option for those care providers interested in working with special populations. It is the law. Some children, such as those with severe disabilities—including the technology-dependent child and children with serious and severe chronic medical problems—may be difficult to integrate fully into child care settings. However, every attempt should be made to achieve integration.

Clearly, as a nation, we are moving toward increased acceptance of special needs youngsters and their families. But we have a long way to go. In a sense, the Americans with Disabilities Act attempts to legislate integration of these children. But it is too early to say how much of an effect it will have. The law says the children must be served. Parents may be reluctant to insist on a placement when they feel their children are not really wanted and may not be in a stable setting. Service providers may also be reluctant to take on such children. It is not fair to expect even the best-run child care centers, geared to a more typical population, to instantly accommodate to the needs of children with severe problems. Change is always difficult, and lack of knowledge can increase anyone's anxiety. In spite of this, many providers *are* willing to try. It is up to the local agencies to provide the training, encouragement, and support necessary to ensure a positive outcome.

WHATEVER HAPPENED TO ERIC?

For several years, Eric did well at the Maiden Choice Center. When he turned 18, he was able to participate in a summer youth employment program. Under the guidance of a carefully selected supervisor, he was able to help with custodial chores. He did so well that, back in school in September, he was phased into another child care program which he could attend with nondisabled peers.

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III. Child Care for Children with Complex Medical Needs

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Advances in medical technology have substantially increased the survival rate of infants and toddlers with special health care needs. Most of these children live at home and have access to appropriate community services; however, some children have needs so profound and complex that their families may become overwhelmed and feel inadequate to care for them in the home. One subgroup of children with special health care needs are technology-dependent or medically fragile, and more recently they have been described as children with complex medical needs.

Community resources in general and child care opportunities in particular may not be available for children with complex medical needs who are at risk for long-term hospital care, institutional placement, or specialized foster care. Families who are able to care for a child with complex medical needs in the home often experience physical, emotional, and financial stress and the loneliness of homebound isolation.

A child care center designed to meet the needs of children with complex medical needs can provide important benefits for family members: respite from unrelenting care needs, support and training to increase the self-sufficiency and confidence needed to care for the child in the home, and the opportunity to pursue educational, job training, or employment options.

Additionally, the center can offer training and consultation to existing and potential child care providers to increase the availability of highly specialized child care in the community.

TARGET POPULATION

The target population for these specialized child care services is defined as infants and toddlers, birth to 3 years, who have complex medical needs. Table 7–1(III) provides descriptions of four different categories of complex medical conditions with corresponding services that may be needed. This was developed after reviewing two documents (Baltimore City Public Schools, 1990; Federal Office of Technology Assessment [OTA], 1987) which provide supplementary information.

It is possible to estimate the number of children with complex medical needs. Between 1 and 2 percent of U.S. children are believed to have a severe, chronic illness with limitations in major activity (Gortmaker & Sapppenfield, 1985). Furthermore, it is estimated that 17 percent of the 2 percent upper range of children with severe, chronic illness will have the most intense needs (categories I through III in Table 7–1[III] (OTA, 1987). Using the total number of children birth to 3 residing in a jurisdiction, it is possible to estimate the number with complex medical needs.

PHILOSOPHY

Children with complex medical needs are entitled to child care which incorporates all of the principles and components of high-quality traditional child care and provides specialized health interventions as needed. The number and complexity of children accepted into a program are decisions made by the child care provider based on program capabilities.

For centers serving children with more complex and/or unstable conditions, at least one full-time registered nurse must be on site at all times. Daily nursing assessments must be completed on each child to detect changes in health status. New or worsening problems can be identified and remediated as early as possible and reduce the need for more intensive treatment or hospitalization. As allowed by law, the nurse can delegate health care procedures to child care staff and provide necessary training and supervision.

Parents should be engaged in daily planning related to the child's medical and development needs. Additionally, they must

Table 7–1(III). *Categories of Complex Medical Needs*

Category	Description	Services Required	Sample Diagnoses
I	Ventilator-assisted or dependent	*continuous* skilled intervention because of following considerations; maintenance of ventilator, suctioning, tracheostomy care, oxygen therapy, assistance with activities of daily living	1. Central Hypoventilation syndrome 2. Respiratory Insufficiency 3. High Spinal Cord Injury 4. Head Injury
II	Chronic respiratory problems	*intermittent* skilled intervention i.e., tracheostomy care, administration of aerosol medications, oxygen therapy, cardiopulmonary monitoring.	1. Bronchopulmonary Dysplasia (BPD) 2. Tracheomalacia 3. Severe Cystic Fibrosis 4. Severe Asthma
III	Other chronic medical problems	intermittent skilled or unskilled intervention i.e., tube feedings, special diet, catheterization, ostomy care, injections, renal dialysis	1. Feeding disorder (Dysphagia) 2. Spina Bifida 3. Severe Seizure Disorder 4. Renal Failure
IV	At risk for medical problems	skilled or unskilled monitoring i.e., apnea monitor, vital signs, medication administration	1. Central Apnea (SIDS) 2. Sickle Cell Anemia 3. Children who have "graduated" from categories I, II, & III

Note: "Skilled" means highly technical nursing skills, including persons trained in the appropriate skill.

receive technical training and support to develop and sustain the skills and confidence necessary to manage their child's medical condition. An increased understanding of the medical condition enhances the parents' ability to discriminate between the expected and unexpected changes in their child's status and therefore become more astute health care consumers. Finally training and support assist parents to foster their child's physical, psychological, and social development; fully integrate the child into family life; and access community resources. Multidisciplinary services are coordinated for each child, as needed, in the center.

PREOPERATION ISSUES

Site and Accessibility

The site selected for the program must be well lighted outside and accessible by both public and private transportation. The facility needs to meet zoning, building, and fire code requirements and must comply with all state and local child care licensing regulations. A sufficient number of electrical outlets must be available for medical equipment. Adequate indoor and outdoor play space is needed to allow freedom of movement with and without adaptive equipment.

Additionally, the center must meet the Americans with Disabilities Act (ADA) standards for accessibility. Ideally, the center should be located in the same building with other early intervention resources. Appropriate hospital facilities should be available within a 15-minute ride from the site. Local fire and rescue workers must be familiar with the center in case of an emergency.

Marketing

Moving an ill child from the sheltered atmosphere of a hospital or home and into a child care center can be a frightening experience for families. Securing the confidence of professionals already working with these families can help lessen the parents' anxieties. Physicians and nurses from the neonatal intensive care units of local hospitals should be invited to visit the center. Practicing pediatricians and other physicians, local health department staff, physical, occupational and speech therapists, early intervention specialists, and other professionals in the community should be informed about the services offered in the center and invited to visit.

Funding

In general, the weekly cost to provide child care for an infant or toddler with complex medical needs is two to three times greater than the cost of traditional child care. It is, therefore, necessary to identify and utilize as many funding sources as possible. Families can be charged based on ability to pay using a sliding fee scale. Medicaid reimbursement for eligible children may be available through either Early Periodic Screening Diagnosis and

Treatment (EPSDT) Expanded Services or medical day care provisions. Some private insurers will reimburse the child care center as a skilled nursing care facility. Other sources of funding include state and/or local child care subsidies (purchase-of-care), the Infants and Toddlers Program, Title V Maternal and Child Health (MCH) Block Grant funds administered by the state health agency, state or local grant funds, foundation grants, in-kind assistance, and fundraising.

STAFFING AND RATIO REQUIREMENTS

Child Care Staff

Child care staff should have baseline training and experience as required by the state child care licensing regulations. Suitable backgrounds for working with children with complex medical needs include early childhood, child care, and elementary and special education.

As with traditional child care settings, staffing patterns follow state requirements and ratios. Depending on the number of children enrolled and the complexity of their needs, staff-child ratios may need to be adjusted periodically, never to exceed the state-mandated ratio. With appropriate training, support, and modifications, child care staff usually find that a child's special needs assimilate rapidly into the daily routine.

Nursing Staff

The amount of nursing services needed in the center will be determined by the number and complexity of children served. It is recommended that when more than one nurse is hired, a nursing coordinator be designated to implement and coordinate the nursing component. The nurse coordinator position assumes increased importance as the medical problems of the children increase in number and complexity, because a nurse must be responsible for supervision of nursing procedures, care planning, policy formulation, and training of child care staff to perform appropriate medical procedures and infection control.

The background of the nursing staff can be crucial in securing a good "fit" between this type of program and the nurses choosing to work within it. It is recommended that licensed registered nurses (with a bachelor's degree in nursing) bring to a program at least 2 years of pediatric and/or neonatal experience in a commu-

nity or home-based setting. Experience in acute care settings may also be helpful. Public health experience is valuable in the specialized child care setting due to the high level of autonomy and independent decision making required. Additionally, community-based nurses usually are comfortable with training and delegating nursing procedures to "lay" people as allowed by law.

Family Liaison

The family liaison or family worker is another position recognized as beneficial to a child care facility for children with complex medical needs. Families play an undeniably important role in a young child's life. Children are totally dependent, and without nurturing and support, will not thrive. For parents to adequately provide for *their* child, however, they themselves must feel their basic needs are being met. Families expecting a healthy newborn frequently are shocked and overwhelmed with the amount of care required by a child with complex medical needs and can benefit immeasurably from the support and resource referral provided by the family worker.

FAMILY SUPPORT AND TRAINING

In addition to the specific responsibilities of the family worker, family support and training are an integral part of a child care program for children with complex medical needs and can also be offered by the child care and/or nursing staff.

Daily communications and interactions serve as important tools for developing parent competencies and capabilities. Through both verbal and written communications staff can assist in teaching and reinforcing appropriate medical and developmental information. Home visits can complement such support. More formally, other types of training can occur if staffing and finances allow. Support groups can be offered to enrolled families to provide an opportunity to meet with others having similar experiences.

Monthly training sessions covering topics and issues related to caring for children with chronic medical conditions can be provided to the families and community by either the program staff or invited community professionals. These sessions can serve as an opportunity to increase the number of child care centers willing to accept children with chronic illnesses.

STAFF TRAINING

Staff training may be perceived as one of the most formidable challenges in caring for children with complex medical needs. While training is necessary and important, it should be viewed similarly to other types of ongoing training for staff—both for new incoming children and also through continued professional development. Fortunately, much of the medical training transfers from one child to another, since many of the same conditions are found within this population.

Child care staff should receive a basic child care orientation, including a handbook and forms to document yearly completion of state-mandated continuing education units: The following training is recommended to assure that child care staff are informed and competent in caring for children with chronic medical conditions:

A. An orientation to medical policies and a handbook outlining guidelines for the center. Along with this orientation, training for frequently used medical procedures should occur (medication administration, bulb suctioning, apnea monitor operation)
B. Hands-on classroom training by the parent, director, child care staff and/or nursing staff unique to each condition (e.g., special care needs, feeding, positioning).
C. Ongoing inservice training session on relevant health care topics. The nursing staff should receive an initial employment orientation, identical to that offered to other staff. Additionally, training should include medical/nursing policies and procedures and an overview of the child care component. Hands-on training should take place with each child during orientation to demonstrate individual care plans. other training may need to occur to refresh nursing skills needed for infrequently performed or unfamiliar procedures. Supplemental training resources may be available through nursing education programs in the community.

INFECTION CONTROL

The nursing coordinator, in collaboration with the director, is responsible for developing, implementing, and monitoring infec-

tion control policies. Infection control is a critical component of programs caring for children with chronic medical conditions who may have higher susceptibility to illness. Also, infection control is important for maintaining optimal health for the staff. The probability of contact with communicable disease increases when caring for young children; therefore, comprehensive policies addressing communicable disease exposure, universal precautions, sanitation of equipment and toys, and cleaning of diapering areas become a cornerstone of the program. Such policies are necessary to assure the health and safety of all involved individuals and are no different from policies already in place in many conscientious child care centers.

CARE PLANS

Nursing staff are responsible for creating a nursing care plan for each child. Ideally the plan should be initiated prior to admission and completed within 1 week of the child's date of entry. The nursing care plan addresses the child's medical needs on a day-to-day basis and should be shared with and have input from the child's family and physician. It should be reviewed weekly and updated every 60 days or more frequently if indicated.

Similarly, the child care staff are responsible for developing an individual, daily care plan to meet each child's care needs. The plan is formulated primarily with the family's assistance but also includes information from the individualized family service plan (IFSP) if available. The child's placement and progress in the program should be reviewed formally approximately every 6 months or when changing age groups or exiting the program. The review should occur at a meeting between the parents, the primary caregivers, the director, and the nursing coordinator. Care plans allow for consistency in meeting children's needs, are usually mandated by federal and state regulations, and lend credibility to a program. The nursing and child care plans must be coordinated to assure compatible goals and objectives.

EQUIPMENT AND SUPPLIES

Child care providers may fear that they will need to purchase costly equipment and supplies to serve children with complex medical conditions. Center policies can vary from requiring parents to pro-

vide all special equipment and supplies necessary for a child's care to having them supply only specialized items. Individual programs have the opportunity to make this determination.

Most traditional child care centers require parents to provide everyday supplies, such as bottles, diapers, extra clothes, and blankets. Many centers also require that parents provide lunch. It follows that families should provide those medical supplies which are necessary for the child's routine care, such as medicines, dressings, tubing, or equipment such as oxygen tanks, apnea/heart monitors, or nebulizers. Equipment which fosters developmental growth will also come from home—walkers, braces, glasses, and specialized chairs. Of the equipment the child care program might provide, adapted toys and supplies would be most warranted.

Programs serving significant numbers of children with medical needs who also are experiencing developmental delays may find it worthwhile to invest in some educational supplies and equipment specifically designed for these children. Examples include form-fitted chairs, switch toys, and positioning rolls and can be purchased from a manufacturer. Some children, however, must have equipment adapted to their individual needs as determined by a physician. Other items that would benefit children with developmental delays can be adapted from "typical" equipment with appropriate advice from a professional. Equipment can be added as needed—it does not need to be purchased or adapted all at once. Early intervention programs already serving children with developmental delays consult on adapting equipment.

For centers serving many children with chronic illnesses, some medical equipment rentals or purchases are recommended. All child care centers should have a complete first aid kit on site with the contents determined by the state child care licensing agency. In addition, it has been found that certain types of medical equipment are used with most children and with much frequency. Examples include stethoscopes, a scale, a blood pressure cuff, medication syringes, and thermometers. Equipment beneficial for emergency backup use may include portable oxygen, a nebulizer machine, suctioning equipment, ambu bags, and a backup generator. Of course, the equipment list will vary depending on the type of program and variety of conditions served. It is important to note that special cleaning is required for all equipment, especially if it is shared by children. Instructions for cleaning, as well as information related to modifications, can be obtained from the manufacturer and/or a

health care professional. Routine cleaning practices are covered by the Occupational and Safety Health Act (OSHA) regulations.

CHILD CARE AND THE INFANTS AND TODDLERS PROGRAM

Most children with chronic medical conditions will be eligible for special developmental, family support, social services, health-related, and educational services, such as those offered under Part H, the Infants and Toddlers Program, of the Individuals with Disabilities Education Act (IDEA). Because chronic illnesses can impact on growth and development, it is recognized that early intervention services are crucial in enabling young children to develop their optimum potential. The child care program can be used as an avenue for introducing families to services such as the Infant and Toddlers Program as well as serve as a site for the provision of early intervention services.

Child care center staff who already work with enrolled families can provide ongoing case management services. Children receiving home-based therapy services for their medical conditions could benefit from individual services provided at the center by the child's private therapist. In this way, the services would be offered in the child's natural setting.

The child care staff also benefit by observing simple therapies which can be incorporated into the daily routine, thereby adding consistency to a child's developmental program. Finally, by accommodating families needing part-time care, the child care program can be used to supplement center-based early intervention services, which typically are offered only on a part-time basis for younger age groups.

TRANSITIONING

Transitioning will occur for a number of reasons. Some families will relocate and seek child care elsewhere, and others may experience changes necessitating withdrawal. Most children chronologically will outgrow the program and move on to other facilities.

Continuance of care, however, may be based on the child's medical condition. An increase in complexity or a decrease in stability of the medical condition may warrant disenrollment due to the center's inability to continue to provide safe and adequate care. At other times the medical condition may subside alto-

gether or improve to such degree that ongoing nursing supervision is no longer necessary.

For whatever reason a child leaves a program, adequate time must be given to the families to prepare for the next placement. This may require months of preparation for a move to the public school system or 2 weeks of searching to secure home nursing care because a child's condition is increasing in complexity. Transitions can be anxiety-producing and may require intensive family support. A file of available programs and resources can be maintained to assist families with the transition. Options may be limited, and it is important to acknowledge this possibility. Based on the type of care needed, the stability of the child, and the resources available for ongoing supervision, center staff may train staff from the new program to provide some services. Training may be done by the parent if a nurse is not available for ongoing supervision in the new setting.

Helping children and families with a change in their lives can minimize the difficulties inherent in leaving a comfortable, secure setting. The child benefits when families feel confident and comfortable with the transition decision.

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IV. Child Care: A Setting for Early Intervention

JOAN KARASIK

The vision of Part H of the Individuals with Disabilities Education Act (IDEA) is that children with disabilities, from the beginning, are able to grow, live, play and learn in the world of family and community. The Early Intervention System for Infants and Toddlers with Disabilities, Part H, requires that the setting or environment in which early intervention services are provided be the most natural environment for the child. This choice of location for services ultimately may affect the outcomes for the infant and his or her family for a lifetime.

"To the maximum extent appropriate, infants and toddlers must be provided early in-intervention services in natural environments, including the home, and community settings such as day care centers, in which children without disabilities participate" (Code of Federal Regulations 303.12[b]). From birth through age two, the home is the most usual setting for young children. In some instances the home of a care provider rather than the child's home can be appropriate for the child. Increasingly, many young children spend the majority of their day in a child care center. It may be better for some young children to be provided early intervention services in a child care setting rather than in a special center for children with disabilities.

THE INFANTS AND TODDLERS PROGRAM

Since the early 1970s, many laws have been enacted which impact on the way services are delivered. Section 504 of the

Rehabilitation Act of 1973 established certain civil rights for persons with disabilities. Public Law 94-142 was enacted in 1975 and provided all eligible children with disabilities, 3 to 21 years old, with a free and appropriate public education in the least restrictive environment.

The Infants and Toddlers Program, Part H, was enacted in 1986 and is being implemented in different ways throughout the United States. Essentially, it is a coordinated, multidisciplinary, interagency program to provide family centered, community-based early intervention services to children, from birth to age three, who have developmental delays or disabilities.

An Individualized Family Service Plan (IFSP) describes child and family needs and strengths, and identifies services that will be provided. These may include services such as speech, audiology, physical therapy, occupational therapy, special instruction, parent education, social work, psychology and counseling, nutrition, and health and nursing. Each family has a service coordinator who is responsible for assuring the provision of services and for linking the family with other services that are needed but which may not be directly linked to the child's specific developmental needs.

Although the child transitions out of the program at 3 years of age, often many needs will continue. Plans must be made for transition to preschool special education or other community services.

IMPORTANCE OF NATURAL ENVIRONMENT

Children grow and develop typically within the context of a family system which provides the earliest behavioral, social, and learning norms in an expanding sphere of living space. The child learns to communicate through language and actions. Skills are acquired, facts are learned, and feelings are developed as the child grows to understand and interact with the world and its occupants.

Children who have developmental disabilities may take longer to learn and may have more difficulty in generalizing what they have learned to new situations than children without disabilities. They can benefit from experiences in settings typical for children of their age, where newly acquired skills are used and reinforced, and where typically developing children provide stimulation and role modeling. Although a special center may provide a concentration of therapeutic resources, it may provide exposure only to children with similar difficulties in speech, cognition, or coordination.

Early childhood specialists stress the critical need for young children with special needs to interact with a variety of typical

youngsters, especially in social-interpersonal skills development. It is often said that children learn more from each other than from their teachers. Young disabled children need to participate in mainstream programs as an essential component to improve peer social competence (Guralnick, 1990).

Strain (1990) sees social skills as the most important indicator of successful postschool adjustment. He reports studies which have assessed social outcomes for children in integrated versus segregated settings that have found integrated settings to be superior.

Authorities, including Strain, warn that it is not enough to insert a child with disabilities into a group of youngsters without disabilities. Conditions must encourage and assist meaningful inclusion. In a 1988 White Paper, the Council for Exceptional Children (McClean & Odom, 1988) pointed out that the factor that determines how well children with handicaps do in mainstream programs seems to be the quality of the educational program rather than merely the presence of normally developing children.

We must emphasize that "natural environment" for a child may not be a single place and that it will change as the child grows and changes. It may not be the place where early intervention therapies are delivered, but it can be a valuable support to growth and learning.

A child who requires intensive services provided in an early intervention center may only spend a few hours a week in this setting. During the rest of the week, this child may be home all day, playing with brothers and sisters, or in a child care center. A hospitalized child with intensive medical care needs may outgrow these needs; it may be possible to provide skilled nursing and monitoring at home or even in a child care setting. A child receiving home services once or twice a week may benefit from an informal neighborhood play group.

The concept of natural environment in relation to its impact on other family members is important to consider. When early intervention services are provided in a home or neighborhood child care, the family may be able to work more closely with therapists, transportation may be easier, and family routines and schedules may be more normalized. When a father picks up his child every evening at the child care center, he can see how his child interacts with children of varying developmental stages and abilities. A mother may feel less isolation and stigma if her child can be in a group with ordinary children. Brothers and sisters may feel more comfortable about someone in the family who is different, if this child can go to his or her own play school with them.

In summary, real benefits for young children can come from participation in natural environments, such as child care centers or family day care homes, whether as the setting for delivery of early intervention services or as part of the child's day where new skills can be learned and reinforced.

BARRIERS AND STRATEGIES

Sitting around the table are mother and baby, service coordinator and the specialists who have been assessing the child's needs. Together, they are writing the individualized family service plan (IFSP). Everyone agrees about the young child's needs. The only place where any of these services are now provided is in a special education center in a school.

"Why?" asks the mother. "How can I take off work every Tuesday and Friday to get him to the center? The Lord knows how I love that baby, but if I don't have a steady job, I'm out on the street, baby and all. Right now, my big need is to find someone who can take good care of him during the day time."

PROBLEMS AND DILEMMAS

Throughout the nation each state is analyzing situations like this and identifying barriers and possible strategies for overcoming these obstacles (Maryland Infants and Toddlers Program, 1992). The list below, largely based on these analyses, suggests actions to be carried out by early intervention personnel, professionals, child care providers, advocates, and families.

Barrier: *Lack of awareness of options*
The family of an infant or toddler with a disability is probably new to the early intervention system and unaware of possible alternatives for location of services.

Strategies: The service coordinator should:
- Provide information about available programs and services and facilitate visits to sites.
- Help develop needed options by working with the family, therapists, child care providers, and others.

Barrier: *Lack of public programs for young children*
Community-based public programs which accept young children with disabilities are few in number. Public programs for infants and toddlers without

identified disabilities are virtually nonexistent. Although Head Start serves a small number of 3 year olds, and must enroll 10 percent of children with disabilities, priority is given to 4-year-olds. The Extended Elementary Education Program (EEEP) targets 4-year-olds exclusively.

Strategies:
- Advocacy for community-based public programs to meet the full-day needs of young children and their families through interagency planning and integrated funding streams.
- Extension of funding for Head start to more 3-year-olds.
- Expansion of Head Start Parent-Infant Centers.

Barrier: *Lack of public funds to support child care*
Even when child care for children with disabilities is available, some families are unable to access services because funding subsidies are not available.

Strategies:
- Increase child care subsidies for income-eligible families.
- Target a percentage of child care subsidy funds for infants and toddlers with disabilities.

Barrier: *Lack of funding for early intervention services in natural environments, such as child care*
When Medicaid and insurance funding is used to cover the costs of certain early interventions, such as physical therapy or health services, these services are required to be provided in clinics or the child's home under certain waivers.

Strategy: Change regulations to permit delivery of early intervention services in varied settings and allow comparable reimbursement for services.

Barrier: *Reluctance of nurseries and child care providers to accept children with disabilities*
Factors contributing to the unwillingness of providers to accept children with disabilities include lack of staff experience, possible need for additional staff, and staff training, adaptive equipment or structural modifications, fear of higher insurance liability, and reluctance to be subject to the regulations and requirements of the early intervention system.

Strategies:
- Inform child care providers about the Americans with Disabilities Act (ADA) requirements, including

the prohibition of discrimination solely on the basis of disability, the requirement to make public accommodations accessible, permissible fees, and prohibition on arbitrary insurance cost increases.

- Provide ongoing consultation and support to child care providers who serve infants and toddlers with disabilities to help them work with the early intervention staff and reinforce skills throughout the week.
- Include child care providers in personnel development activities.
- Involve child care providers in the development of IFSPs, writing into the IFSP any specific consultation and support services to be provided by the early intervention program.

Barrier: *Prohibition on state-funded early intervention services in church-affiliated programs*

Many child care centers are church operated. In some neighborhoods, these may be the only available providers. Although services provided through a religious entity are not covered by the ADA, the child care center may decide to enroll children with disabilities. However, in such centers, the state agency can provide diagnostic services only; no direct service to the child is permitted.

Strategies:

- Clarify the ADA mandate regarding private providers of early intervention services in church-affiliated centers and provide information to all church-affiliated child care programs on ADA.
- Recommend widening the range of regular state-funded services to include delivering regular on-site observation and consultation in addition to diagnostic services in child care centers or family day care homes.
- Encourage church-affiliated child care personnel to participate in inservice activities that can facilitate the inclusion of children with disabilities in their programs.

Barrier: *Lack of understanding about child care as an early intervention service*

When early intervention services are provided in a child care setting, the early intervention program may accept financial responsibilitiy only for the early intervention services. If, however, regular

supervised play with other children is a necessary developmental need and is provided through child care or an organized play group, this could be designated as an early intervention service on the IFSP. This is an important consideration in determining financial responsibility.

Strategies:
- Clarify the distinction between specialized child care as an early intervention service, which may be an entitlement, and child care as a site in which early intervention services may be provided.

Barrier: *Lack of understanding regarding quality of care issues*

Since natural environments in which services are provided may include play groups, family and center-based child care, nurseries, and other settings, local early intervention systems may be uncertain about their responsibility regarding the quality care provided in these settings. Policy clarification from the U. S. Office of Special Education Programs says that when specialized child care is an early intervention service, the program in which it is provided must meet state standards. When the child care serves only as the location in which early intervention services are provided, the early intervention system is no more responsible for the quality of care than it would be for the quality of care in the child's home.

Strategies:
- Provide technical assistance to service coordinators and other early intervention personnel regarding quality of care issues, including assistance to families in choosing care providers.
- Collaboration between families, advocates and public agencies and professional organizations in working to establish consistent quality standards for child care and helping providers attain these standards.

Barrier: *Lack of flexibility in local early intervention programs for provision of services to individual children in multiple locations, including child care centers or day care homes*

Some early intervention systems have been organized to provide services in centers to maximize use of personnel resources, whereas other systems routinely provide home-based services. A limited num-

ber of programs provide early intervention services to an individual child in a combination of locations, and only a few systems provide services in other locations, such as child care centers or family day care settings.

Strategies:
- Provide technical assistance on ways to provide early intervention services in multiple sites to meet the individual and changing needs of children and families. Provide incentives to local early intervention systems which develop and implement innovative practices regarding location of services in natural environments.

Barriers: *Absence of policy regarding excess costs for specialized child care*

While the ADA does not permit child care providers and other programs to charge additional fees solely on the basis of disability, it does allow differential charges for different services. The regulations, however, provide no guidelines for determining rates.

Strategies:
- Obtain clarification of federal ADA regulations and guidelines as they apply to child care.
- Disseminate information on ADA guidelines plus information on funding and tax benefits available to child care providers for structural modifications and other accommodations.

SUMMARY

Federal law requires that, to the maximum extent appropriate, infants and toddlers be provided early intervention services in natural environments, including child care. The provision of services in natural environments benefits not only the child, but also the family. Natural environments are not only an optional setting for the delivery of early intervention services, but also an adjunct to early intervention services, providing opportunities throughout the child's day for learning through interaction with the everyday world and its people.

Child care settings may be appropriate as natural environments for many children. However, many barriers still exist which restrict access of children with disabilities. These barriers can be overcome by strategies which clarify laws, modify regulations, change funding mechanisms, develop inservice training,

provide consultation and supports, and, above all, are sensitive, whenever decisions are made, to the individual needs and strengths of the child and family.

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CHAPTER 8

FINDING FUNDING: SOURCES OF RESOURCES FOR CHILD CARE

JOHN SURR

Anyone with more than a passing acquaintance with child care in the United States has confronted what many in the profession call "the Trilemma." Briefly characterized, the Trilemma means that parents cannot afford to pay what good child care costs, child care providers cannot earn enough money to live on, and children cannot get the quality of care they deserve. The common thread fueling the Trilemma is that good child care is labor-intensive, and those providing child care need to be well-trained, hence, high-quality child care costs more than typical parents can afford and would cost more if child care providers were paid what they deserve.

This chapter identifies some of the ways, using money, that the Trilemma can be overcome or ameliorated. The public is slowly becoming aware that we all will benefit when child care becomes more of a public responsibility which governments previously assumed. Children who have had high quality child care save governments many times their investments in that quality, as they grow up and become productive citizens instead of drains on the public health, welfare, and penal systems. But the

public and the governments have far to go before affordable quality child care that we need is assured. In the meantime, a number of alternative funding sources must be sought to overcome the squeeze of the Trilemma.

This chapter first offers some general fundraising advice, about which one can find supporting literature cited in the table of references. The core of the chapter describes the main sources of finance from the federal government and larger national foundations and corporate giving programs. These later parts of the chapter are annotated lists of possible sources of funding for child care needs, but the descriptions of the funding programs collected are somewhat sketchy, and the funds they describe may not always be available for reasons too detailed to put in this overview.

A description of a program does not mean that the source described will have money available for applicants now, but even in those circumstances a listing may provide some leads to similar sources elsewhere or ideas for similar local sources of finance.

Parents seeking to reduce the burden of child care fees may find federal program information helpful, as well as foundation/corporate giving descriptions. Students of early childhood programs can find descriptions of scholarship help in the third ("training") part of the federal descriptions. Child care providers can find sources of direct support in all categories, as well as in the "nutrition" and "in-kind support" parts of the federal programs, as well as the "intergenerational child care," "buildings and toys," and "religious" categories of foundation/corporate giving descriptions. Those who support the child care profession in other ways, such as resource and referral services, researchers, and organizations concerned with child care, can find helpful program descriptions throughout, but especially in the "resource and referral" part of the federal program descriptions and in the "national initiatives" part of the foundation/corporate giving descriptions.

GENERATING ADDITIONAL DOLLARS FOR CHILD CARE

Finding additional funding from governments, foundations, and businesses has a substantial implicit cost in time, initiative, and management. This cost must be considered when you think of "shaking the money tree." Sometimes a colleague, or a friend with an aptitude for fundraising can be found to take on this task or major parts of it, but there is no substitute for personal

involvement. There are several books of advice on proposal writing and other techniques of finding funding generally, that are listed at the end of this chapter.

For-Profit and Nonprofit Programs

It is much easier to raise extra funding if the recipient is nonprofit for tax purposes (see the description below of that status in paragraph 38 of the federal program descriptions). This is not only because of the deduction any donor receives when giving money or property to a "nonprofit," but also because of the connotation that a nonprofit program is serving a larger public purpose than its owners' pockets. A program that is nonprofit for tax purposes can still pay its managers the fair market value of their services, but it cannot allow them to profit extensively. Nonprofit programs also must maintain separate accounts for each separate grant program they administer, which can be a burden. Even if a child care program is legally for-profit, as with most family day care operations, it still can benefit from a number of the extra funding programs that are available, such as Small Business Administration (SBA) loans, food and milk for the children, and subsidized training for the staff.

Charity or Entitlement

There is a tendency to think that all extra funding for child care involves charity. That is not true. Many large, well-established sources of funding for child care involve government or business assistance that are entitlements. In contrast, an answer to a request for proposals from a government or a foundation, or a request for help through a United Way or other community resources, is an appeal for charity from a very limited source. Donors need to be cultivated, when it is charity. There are many books and articles about how to write proposals for grants, but perhaps the best advice in this respect will come from the people who administer the grant programs, and the written instructions they provide.

Timing

For both grants and entitlements, timing is important. If the deadline for applications has passed, no application, however worthy it may be, will be considered. In addition, many grant

programs that are described below exhaust the year's funding early, and some have continuing relationships with existing grantees that preclude grants in the program to new grantees.

Sources of Funds

Governments

A difficulty with all levels of government funding for child care is that it is insufficient in amount to make any significant dent in the Trilemma. One may hope that this will change, but until it does the available funding often is given to those who find a government program that fits their needs and follow the prescribed procedures to benefit from it, rather than the people who may need it most. That phenomenon is unfortunate for the public interest, but it offers the perceptive an opportunity to ferret out resources that otherwise would be unavailable.

Federal Government. One pervasive problem with federal funding has been described eloquently by Gwen Morgan in *Hitchhiker's Guide to the Child Care Universe* (1991):

> Direct [Federal] funding for early child care and education has had a categorical approach, rather than a policy approach. There is a plethora of programs. As a result, turf issues use much of the energy of the non-system, and specialized administrators seldom have an overview of the whole, usually overestimating demand for their programs. It is difficult to combine funds or to provide continuity for families as their eligibility changes. (p. 45)

A later part of this Chapter lists most of the federal funding streams that help child care in one way or another. The listing illustrates the variety of approaches and institutions that are involved in official efforts to overcome the Trilemma. Some, such as Head Start, provide direct child care services without substantial formalities, and others (such as support for resource and referral services) are much less directly geared toward children. Many of the federal funding programs described below are administered by the states, which may set up their own criteria and procedures in addition to those of the federal government. Most of the funding streams require private applicants to file formal written proposals, fitting the conditions for the grants, to

receive the funding. Grant recipients then usually must file reports on the use of their federal money, and undergo audits. All of these procedures are intended to ensure that the money goes for the purposes for which it was authorized.

State Governments. Most state governments have their own set of programs that provide financial support for child care, in addition to the programs for which they funnel federal money to its beneficiaries. Adams' *State Investments in Child Care* (1992) provides some summary descriptions, comparisons, and analyses of some of these separate state programs, but discussions with local resource and referral agencies and state child care coordinators are likely to be more productive in helping to mobilize state funds.

Local Governments. Some of the more solvent local governments also have independent financial support programs for child care, administered similarly to the programs described above.

Foundations

Some national programs provided by charitable foundations to support child care are described in a later part of this chapter. The source for all these listings is The Foundation Center's *National Guide to Funding for Children, Youth & Families* (1990). The Foundation Center has an abundance of resources to help people who are trying to find a foundation that has funding interests to match their needs. These include books and files organized along many lines to facilitate the pinpointing of just those foundations that are most likely to respond positively to one's needs. The Foundation Center has offices in New York, San Francisco, Washington, DC, and Cleveland, and free access to its publications is maintained in 178 libraries and nonprofit organizations across the country. The information for each foundation provided by the Foundation Center includes principal donors, officers, trustees, directors, and staff; financial data; purpose and activities; types of support; principal limitations; application information; and recent grants for children. Much of this data is needed to decide how to pitch an application to a foundation. Some of it is included below.

Businesses

Also listed with the foundations are a number of national corporate giving programs that have supported child care activities.

Businesses are beginning to realize that they have an important stake in the quality of child care, and one may benefit financially from that realization if ties with the local business community are cultivated. Morgan (1992) pointed out recently that American businesses really have little money to spend, relatively speaking, on charitable contributions. At least ten times as much is spent on employee benefits, and much more is spent on the unassimilated costs of doing business. He felt, on the basis of extensive experience on corporate boards of directors, that the best funding sources for child care from the business world were likely to be from the enlightened corporations that treated improvements in the quality of child care as long-term investments in their future employees and customers, as well as their present staffs and the communities in which they did business. He added that the best consciousness-raising among corporate executives and board members is done by their daughters and grandchildren and that child care programs would benefit from using these contacts when they have had them. Matia Finn, in *Fundraising for Early Childhood Programs* (1982) pointed out that finding a potent and persuasive "champion" for one's cause inside the corporation is the first and most important step in approaching a corporation for support.

Most businesses are eager to support local community institutions that help their employees find good child care, like resource and referral agencies. But they are likely to support specific child care programs only if they have a demonstrable relationship to the business, such as a high enrollment from families of employees or a policy of accepting children of their employees before other children. These ties can be built, and they can be beneficial to both; but poorly managed, they can capture both institutions in an unhappy relationship of misunderstanding and exploitation.

Business and other community support can take a number of forms, and part of the fundraising challenge and delight is in devising a form of assistance that best meets one's needs and those of the benefactor. Some of the forms in use now, in addition to cash and volunteer teacher assistant time, are: (1) loans and loan guarantees; (2) credit references and fundraising services; (3) extension of liability or building or other insurance coverage; (4) free or subsidized rent; (5) free or subsidized utility costs; (5) building maintenance and repair services; (6) vehicle purchase, leasing, or maintenance, free or with a subsidy; (7) accounting services such as bookkeeping, billing, tax return

preparation and payroll preparation; (8) ordering of consumables, supplies, equipment, and services at wholesale cost, or free or with subsidy; (9) inclusion of your employees in their employee benefit plans, such as health and group life insurance; (10) assistance with recruiting staff; (11) communications and graphics/printing services; (12) assistance with legal services or financial planning services; and many others.

Businesses and private donors cannot take tax deductions for the value of services as such, but they can deduct donations of physical property and reasonable overhead expenses such as rental value, computer use, and transportation. But businesses, according to a 1981 study by the Conference Board cited in Finn's 1982 book, do not pay much attention to deductibility in their decisions on supporting child care programs and other worthy causes. The public relations aspect of the financial support and its appeal to the local employees and customers of the business, are likely to be far more persuasive, according to Finn. Business support of child care programs has great potential for the parents who are their employees. Also, increasing numbers of business leaders are becoming aware of the importance of quality in child care to the future of businesses and the present satisfaction of their customers and productivity of their employees.

The Community

Finn (1982) pointed out that the most common form of support for a child care program is the appeal to parents and neighbors for contributions. This can take many forms, from a bake sale to an art auction or a charity dance, or even to a simple letter to parents pointing out that high quality in child care costs more than the fees that are charged them. Programs with a high level of parent involvement often are more successful at these appeals than programs that do not encourage parents to come to social or educational events or help out in the classroom. Events where families or parents can have fun together often raise more money than direct mail or other straight appeals for money; however, they take much more organization and often require a core group of committed parents with free time to put them on. Games of chance can work as fundraisers, if consistent with state and local laws.

Often appeals are limited to the parents of children currently in a child care program, because that is obvious and easiest. If the program wants to raise some additional funds and commu-

nity support, such as for a building fund, the neighbors might be invited to participate through posters or house-to-house leafletting. Larger events such as dances and auctions might engage the local community as a whole, involving publicity and solicitation of business and community leaders. With an adequate data base, graduates of a child care program and their families can be encouraged to participate in some fund raising festivities. This can give a good feeling to both the former and present families in a program. Of course, the more elaborate the fundraising program and its preceding publicity, the more work involved. Some businesses offer, for a fee, to conduct a complete fundraising event. That saves some wear and tear, but it might cost the sponsors some opportunities for personal appeals that a more "home-grown" event would have involved. (See Figure 8–1.)

Conclusion

Successful fundraising requires initiative and a willingness to follow through, but not necessarily a charitable impulse by the source of "quality" funds. Each participant in the child care world has a "market" for additional funds that must be studied. The fundraiser must prepare a presentation, present it, follow up on it, prepare to meet any conditions of the funding, and carry out the program that the funding is designed to facilitate.

The last two parts of this chapter provide brief overall descriptions of two important markets for child care funds. The descriptions summarize what the federal government and the national charitable foundations and corporate giving programs do for child care, and they may help in matching particular funding needs to the purposes for which the funders' resources are dedicated. It is important to remember that most federal grant programs are administered through the states and local governments, and some foundations have regional or even local distribution programs. A similar market survey in the local community must be done before a potentially successful funding proposal can be developed.

FEDERAL FUNDING PROGRAM DESCRIPTIONS

All of the federal data reported below have been discussed with the offices administering the programs described. The descriptions include the purpose of the program, the child care compo-

Figure B–1. Staying afloat and turning on liquidity.

nent, the quantities, conditions and restrictions on the use of the funds, and the amounts and number of beneficiaries involved, all according to the latest data. The order of listing is linked to the type of assistance given, with programs administered by each agency grouped within each type roughly in diminishing dollar value of the child care-related grants within each program. The types of federal assistance described are: Programs Subsidizing Child Care for Parents; Programs Providing General

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Support for Child Care; Programs Supporting Training; Programs Supporting Resource and Referral Services; Programs Supporting Nutrition; In-Kind Support; Expanded Entitlements; and Tax Relief. An index to program titles, with administering agencies and contacts, appears in Appendix D. For information about a program involving grants to States, one should consult the appropriate agency of the state government, which acts as a channel for the federal funds.

In addition to discussions with federal program administrators, the data in this part of the chapter are derived from Blank.(1991), Durbin (1990), Pizzo (1992), Pizzo (1990), U.S. Department of Education (1991), U.S. Department of Health and Human Services and MAXIMUS (1991), U.S. Department of Health and Human Services (1992), U.S. Government Printing Office (1992), U.S. House of Representatives, Select Committee on Children, Youth, and Families (1990), and U.S. Office of Management and Budget (1988).

Programs Subsidizing Child Care for Parents

1. Head Start

Head Start is a comprehensive, community-based child development program administered directly by the federal Government through grants to nonprofit and official agencies that adhere to the Head Start Federal Guidelines and receive 20 percent of their funding apart from Head Start. The program serves mostly 3- and 4-year-olds in 3-hour programs for 4–5 days per week in school or center environments. Supplemental grants fund: (1) 32 demonstration transition programs that also serve older children through the third grade, (2) some demonstration programs that operate all day, (3) 12 enhanced-service programs for homeless children, (4) a child abuse prevention program, (5) some programs that are in family day care homes, (6) 41 Family Service Centers to coordinate assistance to Head Start families, (7) 106 Parent-Child Centers, which serve pregnant women and their infants from birth to age 3, and (8) a Public and Indian Housing Child Care Demonstration Project. Ten percent of Head Start children in a program must have disabilities, and at least 90 percent must come from families with incomes below the federal poverty line ($9,190 for a family of 2 for 1992). Head Start programs provide food, nutrition education, health screening, social services, home visits, parental involvement and education in literacy and child development, and funded staff development. Programs may provide health care services to younger siblings of

enrolled children. Head Start served about 622,000 children in 1,355 programs in Fiscal Year (FY) 1992. For details, contact the HHS Head Start Office at (202) 205-8539.

2. Child Care and Development Block Grant (CCDBG)

CCDBG has a variety of uses, each with its own purposes and restrictions. The child care services portion of this grant, 75 percent of the annual amount disbursed to participating states, territories, and Indian Tribes, ($669.6 million in FY 1993) is restricted to low-income children under 13 years. The family income must be less than 75 percent of the state median income, with a sliding scale for eligible parents. The poorest children and those with special needs have priority. Parents may choose between vouchers for services, or a program that has a contract with the state government or its agent. The state must maintain at least the level of spending on child care prevailing before receipt of Block Grant funds. Parents must be entitled to visit their children on demand. Religious discrimination in enrollment is prohibited. Up to 15 percent of the services portion may be used for administrative expenses, such as an automated voucher system, or quality and supply-building expenses as described in items 20 and 28 below. See also item 12 below; in particular, program support under item 12 provides services to parents equivalent to those under this item. For details, contact the Health and Human Services (HHS) Administration for Children and Families at (202) 401-9326.

3. Title IV-A Child Care: AFDC

Under the Family Support Act of 1988, Aid to Families with Dependent Children (AFDC) recipients must receive child care assistance for their children under 13 years old, or up to age 19 if disabled or supervised by a court, and while the parent is employed or in approved education or job training, including the JOBS program. This entitlement program of matching grants to states was funded at $350 million in FY 1992. Parents must be entitled to choose the provider of care, including relatives, to receive the payments, are entitled to resource and referral services, and must have access to their children in care on demand. Government payments for child care generally must not exceed actual cost and must be at less than the 75th percentile of the market fees paid in the state, or a lower state limit. Title IV-A support must be coordinated with other assistance to the parent. For details on Title IV-A

programs, contact the HHS Office of Family Assistance at (202) 401-9294. Also see items 3A, 3B, 11.e, 19, 22, and 36.b below.

3A. Title IV-A Child Care: Transitional

In addition to child care while on AFDC, most of those whose eligibility for AFDC ceased within a year because of increased earnings or loss of earned income disregard are entitled to continue to receive this assistance for 12 months while the parent is cooperating to have any child support decree enforced, but parents must pay part of the cost under a sliding scale. The federal cost of this assistance was $83 million in FY 1992. Except for the resource and referral requirement and the AFDC income disregard, other Title IV-A conditions apply, as in item 3 above.

3B. Title IV-A Child Care: At-Risk

This program of matching grants to states of between 50 percent and 78 percent of their costs is funded at up to $300 million per year. A state may not use Title IV-A At-Risk funds to supplant its own funding. At-risk child care funding may be made available to low-income working parents at risk of needing AFDC in the absence of subsidized child care. Most other details of the program are as provided for Transitional Child Care, as described in item 3A above, except that the program itself, resource and referral services, and the AFDC income disregard (see item 36.b.) are not required. Forty-two states participated in FY 1991, and 43 in FY 1992.

4. Title XX Social Services Block Grant

This Block Grant, amounting to $2.8 billion in FY 1992, is the remnant of most of the Federal social programs that existed before 1980. Although 45 states in FY 1990 used funds from this source on child care, most of it goes for other social needs. It may not be used for subsistence, medical services, real estate, nonprovider wages, institutional social services, unindexed educational expenses, or cash grants to welfare recipients. For details, contact the HHS Office of Human Development Services at (202) 690-7978.

5. Chapter I Preschool Education

These grants, amounted to $6.1 billion in FY 1992, and are given to school districts to meet the educational needs of children in

public and private schools residing in low-income areas, to alleviate educational deprivation. Some of the funds may be used for preschool programs. About 5.1 million children were in Chapter 1 programs in FY 1989. Additional competitive grants ($5.9 million in FY 1989), made for innovative Chapter 1 programs to increase parental involvement in preschool children's learning, may be available through the Fund for the Improvement of Schools and Teaching (FIRST). In 1992, 33 active grants were outstanding, including several for preschool programs. For details, contact Education's Compensatory Education Programs at (202) 401-1682.

6. Even Start Family Literacy Program

This program provides grants ($89.3 million in FY 1993) to state educational agencies in collaboration with nonprofit or higher education or community-based agencies, for programs integrating early education for children under 7 years old with parenting and parents' basic skills, in a family literacy training framework in participating Chapter 1 areas. Families must make contributions, including in-kind goods or services, of 10–40 percent, increasing in yearly increments of 10 percent. Two hundred thirty-five 4-year grants have been given. For details, contact Education's Division of Program Support at (202) 401-0716.

7. Comprehensive Child Development Centers Act

Thirty-two public or nonprofit projects have been funded (e.g., $47 million for FY 1993) for 80 percent of the cost of quality, comprehensive model child development centers for poor or at-risk people. Funding is provided for quality child care, comprehensive social and health services, nutrition, developmental screening and assessment, and parenting education for the children's families. Extensive data is being collected about these programs for a report due to Congress. Head Start program regulations apply for services similar to those provided by Head Start. For details, contact the HHS Human Development Service at (202) 205-8566.

8. Child Care in Military Installations

The Defense Department subsidizes ($69.2 million in FY 1988) child care and family day care programs on military bases, for expenses of up to $1,000 per child, of training, supervision, coordination with

local governments, and real estate costs, as well as resource and referral for parents, and expenses of obtaining accreditation for some programs. Private sources must account for at least 50 percent of the funding. Accreditation is to be required of all programs later. In FY 1991, 69,380 children were served in 690 centers through this program. For details, contact Department of Defense's (DOD) Office of Family Policy Support and Services at (703) 696-4555.

9. Children with Disabilities

This federal program under the Individuals with Disabilities Education Act (IDEA) supplements available services, through the states, for educational intervention for children with special needs and their families, based on individualized programs and interdisciplinary coordination. Conditions, specified in the Department of Education's Regulations, include a Child Find service, resource and referral for child care, mainstreaming to the extent possible, and evaluation and assessment, grievance, and interagency coordination systems. Part H targeting infants and toddlers through age 2, requires an Individualized Family Service Program (IFSP); older children are provided an Individualized Education Programs (IEP). States may finance child care for children with special needs with available IDEA funds, but it may not be an entitlement. For details, contact Education's Division of Educational Services at (202) 205-8498.

10. Temporary Child Care for Children with Disabilities Program

This program provides states with demonstration grants for 75 percent of their program-related costs, of which 50 percent is for temporary non-medical in or out of home care for children with special needs or chronic or terminal illness, and 50 percent for nurseries for children at risk of abuse or neglect, or children from families supervised by child protective services. Temporary care is provided with a sliding fee scale, but crisis nurseries are available for up to 30 days without fees. One hundred twenty-one grants were made between FY 1988 and FY 1991. For details, contact the HHS Division of Child Welfare at (202) 205-8899.

11. Other Welfare Grants Permitting Child Care Expenses for Recipients, as a Minor Element of Grant Program

This is not an exhaustive listing. If a parent is receiving federal or state public assistance under any program, the philosophy of the

Family Support Act of 1988 and the federal government's interest in having parents capable of employment or vocational training would warrant inquiries into whether child care expenses might be covered, or at least supported, by the program.

a. Job Corps. These residential and nonresidential intensive training centers for welfare or food stamp recipients, can provide on-site or other child care or reimburse such costs. Pilot projects are coordinating these programs with Title XX funds and other welfare programs. For details, contact Labor's Office of Job Training at (202) 523-6871.

b. Job Training Partnership Act. Title II-A provides grants to states and local service delivery areas for employment services, possibly including child care as a supportive service limited to 15 percent of the total, to people below the poverty level or receiving food stamps. Title IV provides grants to public or nonprofit agencies for placement of specialized populations such as farm workers in unsubsidized agriculture or nonagriculture jobs, and the supportive services may include child care during training. For details, contact Labor's Office of Special Targeted Programs at (202) 523-6871.

c. Dislocated Workers Program. This program provides grants for employment or training of dislocated workers, including up to 25 percent for support services that may include child care cost reimbursements. For details, contact Labor's Employment Training Administration at (202) 205-8034.

d. Workplace Literacy Partnership. This program provides grants to public and private partnerships meeting 30 percent of the costs, for training in literacy needed in the workplace, and may include program costs including the cost of child care for participants in nonworking hours. Seventy-three programs were funded in FY 1991. For details, contact Education's Division of Vocational-Technical Education at (202) 205-5421.

e. Title IV-A Emergency Assistance Program. This program provides matching grants to states for temporary emergency financial assistance and services for up to 30 days, through state and local welfare offices, "to avoid destitution" of children and to meet any emergency needs of their families, including child care. In FY 1988, 46,000 families were served by this program. For details on Title IV-A programs, contact the HHS Office of Family Assistance at (202) 401-9294.

f. Consumer & Home Economics Program. Title II of this program permits up to 10.5 percent of the appropriation to be used to fund single parent, displaced homemaker, or sex equity

programs, including child care for participants in vocational education. The state government provides the administrative costs. About 4 million people participate in these programs, under 53 grants. For details, contact Education's Division of Vocational-Technical Education at (202) 205-5421.

g. Resident Management Program. This program provides grants to nonprofit housing agencies to pay the training expenses, possibly including up to .5 percent for child care, of democratically elected residents of low income housing projects receiving training as resident managers. Between 1988 and 1991, 195 groups have been funded. For details, contact HUD's Office of Resident Initiatives at (202) 708-3611.

h. Appalachian Economic & Human Resource Development Program. This program provides grants to states and local governments meeting at least 20 percent of the expenses, to meet specific industry or employer needs, to support economic growth in Appalachia, and may include child care. For details, contact the Appalachian Regional Commission's Executive Director's Office at (202) 673-7874.

i. Indian Child Welfare Act, Title II Grants. This program provides grants ($9.5 million in FY 1991) to tribes and tribal organizations for Indian child and family services, which may include child care on a nonpriority basis. For details, contact Interior's Division of Social Services at (202) 208-2721.

j. Adoptive Parents Respite Care. This program provides competitive grants for public and nonprofit agencies for respite care for adoptive parents, to prevent break-up of placements. For details, contact the HHS Administration for Children and Families at (202) 205-8671.

k. Bilingual Education Programs Special Populations Grants. These competitive grants ($110.8 million in FY 1989 for all programs) provide educational services in bilingual programs becoming self-sufficient in local school districts for English language instruction of children most in need. Parents and community must be involved. In FY 1988, 233,594 children were served in all programs. For details, contact Education's Office of Bilingual Education & Minority Languages Affairs at (202) 205-5463.

l. Native Hawaiian Education Assistance Program. One of the 5 program areas served by these grants ($4.9 million for all areas in FY 1989) is for Native Hawaiian family based education centers, serving children from the prenatal stage through age 5, and their parents. For details, contact Education's Division of Discretionary Grants at (202) 401-0113.

m. Higher Education Act Reauthorization, 1992. This Act includes a program of Special Child Care Services for Disadvantaged College Students which makes grants, but none to institutions of higher education to pay for those services.

Programs Supporting the General Operating Expenses of Child Care Providers

12. Child Care and Development Block Grant

Twenty-five percent of the Block Grant funding is available for program support and quality enhancements. For details, contact the HHS Administration for Children and Families at (202) 401-9326.

a. Program Support. Less than 20 percent is administered through the states, and is reserved for grants and contracts to help early childhood development and nonacademic before and after school care programs. This portion of the CCDBG has no cap on administrative expenses.

b. Quality Enhancements. Five percent of the Block Grant, administered through the states, is reserved for assistance in meeting regulatory requirements, improving child care professional compensation, training (see item 20 below), and discretionary amounts for quality improvements in general. Quality enhancements may be financed by some other Block Grant elements.

13. Small Business Loan Programs

The Small Business Administration gives a variety of forms of assistance to small businesses, including for-profit child care centers and family day care homes. This includes direct loans, loan guarantees, and venture capital from regional Small Business Investment Companies. It also includes loans in area-wide disasters, and management assistance courses, conferences, counselling, booklets, and research. For details, contact your nearest SBA office.

14. Dependent Care and Development Block Grant

This program provides grants to states (with a 25 percent matching requirement) for planning, developing, or establishing before and after school care for children up to age 13. Any ongoing operations must benefit low-income children and must include parental involvement and cultural diversity, especially children with special needs. The grant may not be used for operating or capital costs or direct payments to families needing child care. 56 grants were

made in FY 1991. For details, contact the HHS Administration for Children, Youth and Families at (202) 205-8034.

15. Medicaid Reimbursements

Since 1990, Medicaid, which makes matching grants through states, will reimburse a child care program for its costs of (a) transporting a covered child to and from medical services, (b) developmental screening, (c) case management, and (d) any treatment or remediation services. Some state child care appropriations may be used to meet a federal Medicaid matching requirement. For details, contact the HHS Office of Prepaid Health Care at (202) 619-0815.

16. Early Education for Children with Disabilities

This program provides grants to public and nonprofit agencies for children under 8 years old with disabilities. The grants may be used for: (a) demonstration preschool or early intervention programs that provide technical assistance and collaborate with other programs; (b) research institutes on special education for young children and to meet the specific special needs of a young child; (c) experimental projects; and (d) in-service training for those serving children with special needs. Demonstration, experimental, and outreach projects must provide a 10 percent match. One hundred to one hundred thirty projects are funded. For details, contact Education's Division of Educational Services at (202) 205-9084.

17. Public Housing Child Care Demonstration Program

This program provides grants ($4.8 million in FY 1991) to public or nonprofit agencies for child care facilities in low-income housing projects, and to assess the usefulness of such care for parental training and employment. Priority is given for start-up costs and the employment of residents in the facilities. 22 grants were made in FY 1990. For details, contact Housing and Urban Development's (HUD) Division of Economic Development and Supportive Services at (202) 708-4214.

18. Other Federal Programs Providing Incidental Support for Operating Expenses of Child Care Programs

A few federal programs provide explicitly for incidental support for child care programs that fit their needs. In addition, most of the federal training, in-kind assistance, and nutrition programs

described below in other sections provide support for the operating expenses of child care programs.

a. Child Welfare Research and Demonstration Projects. This program provides competitive grants to public and nonprofit agencies for research and demonstration projects in child welfare, which may occasionally include child care. For details, contact the HHS Children's Bureau at (202) 205-8588.

b. Child Welfare Service Grants. This program provides grants to states for child welfare services to children and their families, possibly including child care. There is no cap on the family's income. For details, contact the HHS Children's Bureau at (202) 205-8740.

c. Community Development Block Grant. This large program provides grants to states and communities with more than 50,000 people that must meet matching requirements, for economic development to benefit low and moderate income people, to reduce slums and urban blight, and to address urgent health and safety needs. Child care expenses, including the purchase or use of real estate, may be included, but no direct grants are made to child care centers. HUD conditions must be met. For details, contact HUD's Community Planning and Development Division at (202) 708-3587.

d. Community-Based Integration Projects. This program provides 2–5 grants for multi-disciplinary local planning and coordination of services to children, youth and families. Child care may be included within the coordination component. For details, contact the Office of the HHS Assistant Secretary for Planning and Evaluation at (202) 690-7858.

19. Title IV-A Child Care Improvement Grants.

This program provided 10 percent matching grants to states for meeting the state and local government costs of licensing or registration requirements, and for enforcing child care standards. See items 3, 3A, 3B, 11.e., and 22 for related programs; one half of any grant must be used for training as described in item 22. For details on Title IV-A programs, contact the HHS Office of Family Assistance at (202) 401-9294.

Programs Supporting Training

20. Child Care and Development Block Grant

One of the possible uses of the quality portion of this grant administered through the states, is for training and technical assistance for child care providers. See items 2 and 12.b above

and 28 below for general conditions and alternative uses. For details, contact the HHS Administration for Children and Families at (202) 401-9326.

21. CDA Scholarship Assistance

This scholarship program provides grants through the states for the costs for child care providers having income below 195 percent of the Lower Living Standard, to obtain the Child Development Associate Credential, sponsored by the Council on Early Childhood Professional Recognition, whose administrative expenses the federal government must now support. Up to 35 percent of the scholarship may be used for training, and the remainder pays the Council's fee, which the government keeps at $325. For details, contact the HHS Head Start Office at (202) 205-8347.

22. Title IV-A Child Care Improvement Grants.

At least one-half of any grants described in item 19 above must be used for training. For details on Title IV-A programs, contact the HHS Office of Family Assistance at (202) 401-9294.

23. Higher Education Act of 1992

This authorizing legislation initiated or continued a number of programs primarily or incidentally directed toward funding education and training for early childhood professionals. For details of all prospective programs, contact Education's Office of Post-Secondary Education at (202) 708-9069.

a. Early Childhood Staff Training and Professional Enhancement Grants. This program provides competitive grants to the states for them to develop comprehensive plans for early childhood professional preparation and continued training, based on help from broadly based advisory committees, and assessments of training resources, needs, and standards, staffing patterns, and coordination efforts in place.

b. Early Childhood Teacher Training and Violence Counseling. This program provides grants to institutions of higher education, to recruit and train students for careers in early childhood development and care, or to provide counseling to children ages 0–6 who have been exposed to violence and adults who work with them. For details, call Education's Office of Post-Secondary Education at (202) 708-8391.

c. Teacher Corps. This program funds among others, the educational expenses of up to $5,000 per year in 2-year Associate degree programs and 1-year Child Development Associate (CDA) credential programs, for preschool teacher candidates, who get special consideration for selection by the Senate, and other teacher candidates. Recipients must teach for 3 years at elementary schools identified as having the highest levels of poverty and student achievement. For details, call (800) 4-FEDAID.

d. Paul Douglas Teacher Scholarships. This program funds scholarships for high school graduates (top 10 percent) to pursue teaching careers, now including preschool education. For details, call Education at (202) 708-9453.

e. Perkins Loans. Loans are cancelled for eligible full-time special education teachers and certain providers who care for children needing early intervention services or high-risk children from low-income communities. For details, call (800) 4-FEDAID.

f. Teacher Excellence Support. Programs by states and localities to update and improve the skills of classroom teachers including early childhood education specialists, in areas such as: recruiting people into the profession, providing in-service training programs, studying statewide teacher education programs and standards, and establishing state teacher academies.

24. Special Education Training Grants

This program provides grants to institutions of higher education or public or nonprofit agencies for training personnel for careers in special education or early intervention or related services. Grants meet the cost of tuition, fellowships, traineeships, stipends or allowances, and general program support. Grants to about 4,000 trainees and 14,000 others supported indirectly are awarded, based on shortages of trained personnel. For details, contact Education's Division of Personnel Preparation at (202) 205-9554.

25. Foster Grandparents Program

This program provides grants to meet 90 percent of the expenses of public and nonprofit agencies in training and supervising low-income people at least 60 years old in the care of children under 21 with special or exceptional needs. Each trainee receives 40 hours' training and close supervision in the care of 3 or 4 chil-

dren for 20 hours per week. In FY 1991 there were 262 projects, involving 24,000 volunteers. In 1988, 68,000 children were served. For details, contact ACTION at (202) 606-4849.

26. Other Federal Programs With Incidental Support for Training

a. Child Abuse and Neglect Prevention Grants. These are national demonstration programs and grants to states for the prevention of child abuse or neglect, and may be used, among other purposes, to train child care providers on these topics. The state must meet reporting and investigation requirements, and matching funds may be required in a national demonstration project. For details, contact the HHS National Center on Child Abuse and Neglect at (202) 205-8910.

b. Vocational Education Act. This program provides grants to states for vocational education, which may include education and structural programs preparing youth and adults to work in child care, as well as other vocations. Title II, serving occupational home economics, single parents, displaced parents, and teenage pregnant women, has served about 4 million women. Title III concerns consumer and homemaking education. The recipient state provides administrative costs. Fifty-three grants were in operation in FY 1992. For details, contact Education's Division of Vocational-Technical Education at (202) 205-5421.

Programs Supporting Resource and Referral Services

27. Dependent Care and Development Block Grant

This program provides grants to states for 75 percent of their costs of supporting, among other programs, resource and referral systems for care of dependents with a developmental disability or under 17 or over 55 years old. See item 14 above for general conditions and alternative uses. For details, contact the HHS Administration for Children, Youth and Families at (202) 205-8034.

28. Child Care and Development Block Grant

One of the uses of the quality portion of the Child Care and Development Block Grant (CCDBG) grant is to support resource and referral programs. See items 2, 12.b, and 20 above for general conditions and alternative uses. For details, contact the HHS Administration for Children and Families at (202) 401-9326.

Programs Supporting Nutrition

29. Child and Adult Care Food Program

This entitlement program provides grants of funds and commodities through states for meals served to children who are under 13 years old or, if older, migrants or under 16 and disabled. Family day care homes and for-profit centers with at least 25 percent funding from Title XX, and nonprofit centers, are eligible for support. Legal family day care homes are reimbursed by standard breakfast, lunch, and dinner fees. Centers are reimbursed according to factors including a set rate per meal; breakfast, lunch, or dinner; and the child's family income. In FY 1992, 169,141 sites were supported and 1.3 million children were served in 1989. For details, contact Agriculture's Food and Nutrition Service at (703) 756-3947.

30. Special Milk Program

This entitlement program provides grants through the states at a set rate per half-pint for milk served without discrimination to children in nonprofit nursery schools and child care institutions, except for children in other federally subsidized food programs (except wrap-around kindergartens). The provider may provide all needy children with free milk, or provide subsidized milk to all children. One million children were served in FY 1988. For details, contact Agriculture's Food and Nutrition Service at (703) 756-3590.

31. Summer Food Service Program

This entitlement program provides funds and commodities through the states for up to two meals per day (4 for migrants), served from May through September to children in low-income areas. The provider must meet USDA nutrition and financial management conditions. In FY 1988, 1.6 million children were in this program. For details, contact Agriculture's Food and Nutrition Service at (703) 756-3590.

Programs Providing In-Kind Support

32. Surplus Property Disposal

Nonprofit and public child care centers are eligible to receive, without any federal fee but often with a state handling fee, free surplus federal property. The property must be used within a year of acqui-

sition, and the state governments administering the program may impose other conditions. For details, contact the General Service Administration's Federal Supply Service at (703) 557-1234.

33. Child Care in Federal Buildings

Centers with at least half of their families including a federal employee may negotiate agreements for cost-free space and utilities in federal work spaces. Other operating costs are not subsidized. Children of federal employees are preferred over other applicants for enrollment. For details, contact in the General Service Administration's Office of Child Care and Development Programs at (202) 501-3965.

34. Inexpensive Book Distribution Program

Reading Is FUN-damental, Inc., will distribute free or low-cost books to children over 2 years old at federal cost for books for children of migrant or seasonal farm workers, and with 75 percent federal support for others. For details, contact Education's Division of Formula Grants at (202) 401-1059.

34A. Ready to Learn Television Act

This program, if funded, would provide grants to develop and distribute educational video programming to promote school readiness for preschool children. Some videos and support materials would be given to providers directly. For details, contact Education's Office of Educational Research and Information at (202) 219-2164.

35. Clearing House on Work & Family Choices

The Clearing House provides technical assistance, primarily to employers and labor organizations, on work and family issues, including child care. For details, contact Labor's Women's Bureau at (202) 523-4486.

Added Federal Benefits Reflecting Child Care Costs

36. Child Care Disregards

These programs as well as the Earned Income Tax Credit described in item 40 below, disregard the costs of child care for purposes of computing his or her parents' income in order to determine a family's federal benefits:

a. Food Stamp Program. Dependent care expenses are limited to those needed for the parent's work, training, or education.

b. AFDC. If a parent is working and pays dependent care expenses while applying for or receiving AFDC, the corresponding income is disregarded. For details, contact the HHS Office of Family Assistance at (202) 401-9294.

c. Public and Indian Housing Program, and Section 8 Housing Program. These programs deduct reasonable child care costs up to the amount of employment income from family income for rental rate calculations. For details, contact HUD at (202) 708-1015.

d. Child Care and Development Block Grant. Under legislation passed in FY 1992, the value of subsidized child care under the CCDBG (items 2 and 12 above) is deducted from income for purposes of determining eligibility for other federal benefits, except possibly the Child and Adult Care Food Program (see item 29 above). For details, contact the HHS Administration for Children and Families at (202) 401-9326.

37. Child Care Cost Inclusions in Living Costs for Federal Scholarships

The amounts of scholarships granted in the following federal scholarship programs included the costs of child care for the recipients: (a) Pell Grants (added cost limited to $750) (contact Education at (202) 708-9896); (b) Supplemental Education Opportunity Grants (contact Education at (800) 433-3243); (c) State Student Incentive Grant Program (contact Education at (800) 333-4636); (d) Guaranteed Student Loan Program (contact Education at (202) 708-9776); (e) Perkins Loan Program (contact Education at (202) 708-4690); (f) Income-Contingent Loan Program (contact Education at (202) 708-4690); and (g) Work-Study Program (contact Education at (202) 708-4690).

Federal Tax Relief Targeted to Child Care

For all tax questions, the Internal Revenue Service prefers that their (800) numbers be used to get details: call (800) 829-4477 for a voice tape describing a section or problem or form, (800) 829-1040 for taxpayer assistance, and (800) 424-FORM for tax forms.

38. Nonprofit Child Care Center Exemption

A center that receives its own or a derivative nonprofit tax status is exempt from income tax on child care-related business, and may receive contributions that contributors may deduct from their

income for federal tax purposes. The child care center must include at least 85 percent children of working parents; be open to the general public; avoid discrimination because of race or because of the children of a specific employer (note that other non-profit status may be available for employer-discriminators); avoid political activity; receive only incidental revenue from sources other than child care; make no private distribution of profits; and have its application for Section 501(k) status approved.

39. Parent-Related Tax Relief

A parent with child care expenses may choose only one of these two forms of tax relief:

a. Child and Dependent Care Tax Credit. Employment-related expenses up to the amount of earned income can be credited against income tax for the care of a child under 13 years old or disabled, if the provider's Social Security number is reported. The limits on the expense are $2,400 for one child and $4,800 for more than one, with a maximum tax credit of $720 for one child and $1,440 for more than one. If the taxpayer's income exceeds $10,000, the 30 percent credit is reduced by 1 percent for every $2,000 of additional income, up to $28,000, above which the credit is 20 percent. The creditable expenses are reduced by any exclusions from income under a related Dependent Care Assistance Plan (see item 38.b. below).

b. Employer-Provided Child Care Services or Allowances. If an employer has a dependent care assistance plan (D-CAP), either standing alone or as part of a benefits cafeteria plan, an employee who needs care for children in order to work, may exclude from income for federal tax purposes, the amount of child care expenses reimbursed (or the value of the services provided), up to $5,000 (or $2,500 if married and filing separately). The employer's plan must not favor its owners, officers, or most highly paid employees, and the eligible children must be under 13 years old or disabled.

40. Earned Income Tax Credit (EITC)

This refundable income tax credit applies to anyone, including providers, their employees, or parents, whose families earn less than about $22,000 per year. It provides a credit against federal income tax liability, or a cash refund, or advance installments from the employer, of up to about $2,100 per year. Factors influencing the amount of the credit include family income, number

of children, whether any children are under 1 year old, how much the family health insurance costs, and the rate of inflation. The EITC is disregarded for other Federal benefit programs (see item 35 above). The infant credit will not be paid if a parent uses the benefits described in item 37 above. The IRS will compute the EITC if the taxpayer requests.

DESCRIPTIONS OF NATIONAL FOUNDATIONS AND CORPORATE GIVING PROGRAMS

This part of the chapter relies primarily on the data furnished in the *National Guide to Funding for Children, Youth, and Families*, (Copyright © 1990 by the Foundation Center, 79 Fifth Avenue, New York, NY 10003-3050) ("*The Guide*"), which provides sufficient information for applicants to apply for grants from the 2,738 foundations that they list as having made, or as being prepared to make, grants to benefit children, youth, and families. The Foundation Center has kindly authorized the use of that information in this publication. The descriptions below lack some of the specificity of the descriptions in *The Guide*, so reference to copies of it in public libraries in the larger cities, or ordered at a cost of $125 from The Foundation Center, 79 Fifth Avenue, New York, NY 10003, is recommended. A Foundation Center biennial publication, *Grant Guide for Children and Youth*, (1992, $60), gives more recent examples of foundation grants in this area.

The descriptions below are arranged alphabetically by the last name of the foundation or corporate giving program, within the following categories: Local Child Care Programs, National Child Care Initiatives, Intergenerational Child Care, Buildings and Toys, and Religious Child Care Programs.

Funding for Local Child Care Programs

Of the approximately 275 recent foundation grants indexed under "Children, day-care" in the *National Guide to Funding for Children, Youth, and Families*, only about 40 were available beyond the city or state in which the granting foundation is headquartered. The locally available grants are not listed below, because of space limitations; however, local organizations should look to the charitable foundations and corporations in their own communities first, before they seek assistance from the national

foundations and corporate giving programs. The relatively few national foundations and corporations that do provide grants to local child care organizations usually are supporting initiatives to meet problems that are nationwide in scope, programs whose successes might be repeated elsewhere, or programs in the cities where the corporate donor has significant operations.

Recently, under a Rockefeller Foundation grant, a Coalition of Community Foundations for Youth (CCFY) was founded, so that local foundations could work together to promote the interests of children through grassroots organization, media campaigns, and public advocacy. Linking up with a local group like this could end up being remunerative. (New Partners: Community Foundations & Advocacy Groups. The Child Advocates' Information Exchange (1992)).

1. Aetna Foundation, Inc.

Kelly Bedard, 151 Farmington Ave., Hartford, CT 06156; (203) 273-6382. In 1989, grants were $8,139,082, and 43 recent grants reported in The Guide included 1 for child care in Hartford. Grants are for programs that solve social problems and stimulate other donations; priority for revitalizing urban neighborhoods. No grants to: religions, individuals, capital funds, operating budgets, or computer hardware. Board meets in months numbered 2, 5, 7, and 11. File one copy of proposal summary in letter.

2. Atlantic Research Corporate Giving Program.

Corporate Community Office, 5390 Cherokee Ave., Alexandria, VA 22132; (703) 642-4000. Grants are for child and family services and education, where the company operates or its employees live.

3. Kathleen Price and Joseph M. Bryan Family Foundation.

Robert K. Hampton, Executive Director, 1 N. Pointe, #170, 3101 N. Elm St., Greensboro, NC 27408; (919) 288-5455. Sixty-three 1989 grants were $1,418,425. Grants are in early childhood education, primarily in the Southeast, especially North Carolina. No grants to: private foundations, individuals, research, or fundraising drives. Send letter by 3/1, 9/1. Board meets 5 and 11.

4. Burlington Northern Foundation

Don S. Snyder, Vice President, 3000 Continental Plaza, 777 Main St., Fort Worth, TX 76102. In 1988, 943 grants were $14,086,111, and 48 reported grants included 1 for a child care center. Grants are for social services primarily in areas of company operations. No grants to: religions, fraternal organizations, national health programs, chambers of commerce, taxpayer associations, bodies that might benefit the company, political activities, individuals, hospital operating budgets, fundraising events, endowments, or scholarships.

5. Patrick and Anna M. Cudahy Fund

Sr. Judith Borchers, Executive Director, P.O. Box 11978, Milwaukee, WI 53211; (414) 271-6020. In 1988, 98 grants were $1,078,277, and 8 reported grants included 2 for child care centers. Grants are for social services and the homeless and education in Milwaukee or Chicago, and for national programs. No grants to individuals or endowments. Send letter at least 6 weeks before Board meets 4, 6, 9, and 12.

6. Dayton Hudson Foundation

Cynthia Mayeda, Chair, 777 Nicollet Mall, Minneapolis, MN 55402; (612) 370-6555. In 1989, 375 grants were $11,452,875, and 78 reported grants included 4 for family to family child care initiatives in several localities. Grants are for social action programs that help individuals make economic and social progress and to develop strategies to meet community, social, and economic concerns, primarily where its retail operations are. No grants to religions, individuals, scholarships, conferences, or tax-supported activities. Send letter and proposal. Board meets 3, 6, and 12. This Foundation is related to the Target Stores Corporate Giving Program (see item 19 below).

7. Echlin Corporate Contribution Program

R. A. Wisot, Treasurer, 100 Double Beach Rd., Branford, CT 06405; (203) 481-5751. In 1988, grants were $300,000. Grants are for child welfare and development in communities with Echlin employees.

8. Gannett Foundation

Charles L. Overby, President, 1101 Wilson Blvd., Arlington, VA 22209. In 1988, 2,687 grants were $23,301,011, and 375 reported grants included 24 for child care centers and resource and referral services in communities with Gannett Co. operations. Grants are for local nonprofit educational and social service agencies and volunteerism. No grants to: national or regional organizations, research unrelated to foundation purposes, religions, political or fraternal groups, primary or secondary education not helping the exceptional or disadvantaged, individuals except employee-related scholarships, annual campaigns other than United Way, or endowments. Board meets 3 or 4 times a year.

9. The Hearst Foundation, Inc., and The William Randolph Hearst Foundation

Robert M. Frehse, Jr., Executive Director (east of Mississippi River), 888 7th Ave., 27th Floor, New York, NY 10106; (212) 586-5404; or Thomas Eastham, VP and Western Director (west of Mississippi River), 90 New Montgomery St., #1212, San Francisco, CA 94105; (415) 543-0400. THFs 271 1989 grants were $5,571,000, and 143

reported grants included 3 for child care centers. TWRHF's 271 1989 grants were $8,387,500, and 87 reported grants included 3 for child care centers. Grants are for programs to aid poverty-level and minority groups, serving more than a narrow community. No grants to: political activity, individuals or fundraising events. Board meets 3, 6, 9, and 12.

10. The Robert Wood Johnson Foundation

Edward H. Robbins, Proposal Manager., P.O. Box 2316, Princeton, NJ 08543; (609) 452-8701. In 1989, 412 grants were $98,600,000, and 99 reported grants included 1 grant for $1,831,191 for service referral and child care for mothers and children from AIDS-infected families. Grants are for improvement of health services and for rehabilitation, especially for underserved population, in demonstration projects and, if successful, their offspring. No grants to: individuals, conferences, operating expenses, or endowments. Board meets quarterly.

11. Kiwanis International

Christopher J. Rice, Director of Program Development, 3636 Woodview Trace, Indianapolis, IN 46286-3196; (800) 879-4769. Over 8,800 local Kiwanis Clubs and 46 regional districts are participating in the "Young Children: Priority One" program, indefinitely, to address the needs of children, prenatal through age 5. Each local Kiwanis Club is asked to develop a project in one of four areas of need, including child care and development, either on its own or in collaboration with other Kiwanis Clubs or other local organizations. Detailed Service Bulletins on 13 areas of specific need, including Head Start and Parenting Education, are available from the International office. Club service projects average at $250 and 40 hours of service, but can involve much more of both. Contact should be made with the local club, or with the Young Children: Priority One Committee Chairmen in the Club's District. Clubs welcome program presentations or exhibit booths at their district meetings. The Club's fiscal year begins October 1.

12. Knight Foundation

Creed C. Black, President, 1 Cascade Plaza, Akron, OH 44308; (216) 253-9301. In 1989, 337 grants were $16,665,311, and 110 reported grants included two for child care centers. Grants are for social service programs in cities with Knight-Ridder newspapers. No grants to: grantmakers reaching more than a community, disease alleviation, religions, politics, individuals, funding drives/events, operating funds, bands, media coverage, honoraria, research for publication or on medicine, group travel, or memorials. Send two copies of letter with proposal by 1/1, 4/1, 7/1, or 10/1.

13. Ronald McDonald Children's Charities

Ken Braun, VP, McDonald's Plaza, Oak Brook, IL 60521; (312) 575-7048. In 1988, 162 grants were $4,369,764. Grants are for cultural and educational activities to help children lead healthier and happier lives. Apply with four copies of application form; board meets four times yearly.

14. Charles Stewart Mott Foundation

Judy Samuelson, Director of Communications, 1200 Mott Foundation Bldg., Flint, MI 48502-1851; (313) 238-5651. In 1989, 476 grants were $43,795,989, and 66 reported grants included 1 for child care in Flint. Grants are for community improvement and education, fostering better delivery of services, and counteracting root causes of alienation. No grants to: individuals, scholarships, or endowments. Board meets 3, 6, 9, and 12.

15. David and Lucile Packard Foundation

Colburn S. Wilbur, Executive Director, 300 2nd St., #200, Los Altos, CA, 94022; contact (415) 948-7658. In 1989, 354 grants were $27,675,502, and 92 reported grants included 11 for child care in California and Colorado. Grants are for homeless children, child welfare, child health and education. No grants to: religions, individuals, or endowments. Send proposal by 1/2, 4/1, 7/1, or 10/1.

16. The Pillsbury Foundation

Dianne Brennan, Executive Director, Mail Station 37X5, 200 So. 6th St., Minneapolis, MN 55402; (612) 330-5434. From June 1988 to May 1989, grants were $4,518,347. Grants are for prevention programs for disadvantaged children, to reduce/eliminate causes of child poverty and contribute toward their full development, primarily in company employment centers. No grants to: religions, health organizations, individuals, fundraising, travel, or endowments. Board meets bimonthly.

17. Public Welfare Foundation, Inc.

C. Glenn Ihrig, Executive Director, 2600 Virginia Ave., N. W., #505, Washington, D.C., 20037; (202) 965-1800. In 1989, 341 grants were $12,331,100, and 130 reported grants included 5 for child care, all for employment/child care for teen families. Grants are for grass roots community service programs serving short-term needs of underclass. No grants to: religions, individuals, conferences, scholarships, deficit financing, research, or endowments. Send letter with proposal. Board meets in 3,6,9, and 12.

18. The Starr Foundation

Mr. Ta Chun Hsu, President, 70 Pine St., New York, NY 10270; (212) 770-6882. In 1988, 327 grants to institutions were

$20,305,018, 359 '88 grants to individuals were $842,004, and 31 reported grants included 1 for a child care center. Grants are for education, health, welfare, and social sciences. No grants to: individuals (except through scholarship programs) or matching gifts. Board meets 2 and 9.

19. Target Stores Corporate Giving Program.

Susan K. Anderson, Manager, Community Affairs, 33 S. 6th St., PO Box 1392, Minneapolis, MN 55440; (612) 370-6098. In 1989, grants were $3,899,630. Grants are to support social action and to develop strategies that respond effectively to critical concerns, especially strengthening family life in Target Stores communities. No grants to religions, individuals, or fundraisers. Initiated in 1991, $9,000,000 Family to Family program, works to improve family child care by recruiting, training, and accrediting family child care providers in 15 communities, by organizing family day care associations, by promoting public awareness of the need for quality in child care, and by public policy advocacy. Target is related to the Dayton Hudson Foundation (see item 6 above).

20. Toyota USA Foundation

Kimberly Byron, 19001 S. Western Ave., Torrance, CA, 90509; (213) 618-6766. In 1989, 9 grants were $220,000, and 2 reported grants included 1 for child care. Grants are for community services, minorities, and education programs aiding minorities. No grants to: religions, public action organizations, individuals, or travel, conferences, or deficits. Send letter by 2/15, 5/15, 8/15, and 11/15.

21. TRW Foundation

Laura L. Johnson, Manager, 1900 Richmond Rd., Cleveland, OH 44124; (216) 291-7166. In 1988, 367 grants were $5,610,212, and 17 reported grants included 1 for child care initiative. Grants are for education, welfare, and youth programs in TRW plant communities. No grants to: religions, fraternal or labor organizations, private elementary or secondary schools, individuals, or endowments. Send proposal in 8 or 9 for 12 Board meeting.

22. United Way of America.

Laurie Ryan, Director of the Early Childhood Development Initiative, c/o Honeywell, Inc., MN 12-5300, P.O. Box 524, Minneapolis, MN 55440; (612) 870-6845. United Way helps to organize local "Success by Six" initiatives in metropolitan areas, to mobilized business and community support for early childhood development programs in the local community, and to raise the consciousness of the public about the need for and cost of

quality in these programs. Particulars of support vary according to the community in which the program is developed and takes place.

Funding for National Child Care Initiatives

1. AT&T Foundation

Sam A. Gronner, Secretary., 550 Madison Ave., New York, NY 10022; (212) 605-6734. In 1989, 849 grants were $25,974,595, and 20 reported grants included 1 for women and child care project. Grants are for national social action projects. No grants to: religions, individuals, conferences, local chapters of national organizations, secondary schools/junior colleges, medical research or associations, or sports activities. Send letter and proposal; board meets 3, 6, 9, and 12.

2. The Ben & Jerry's Foundation

Annie L. Sherman, Administrator, Clinton Hall, 108 N. Cayuga St., Ithaca, NY 14850; (607) 272-1813. In 1988, 106 grants were $298,757. Grants are for projects which facilitate progressive social change for children and families. Ben & Jerry's, Inc., has joined the Children's Defense Fund in 1992 with a new line of ice cream products, part of the net proceeds of which is to benefit young children. No grants to: religions, state agencies, or individuals. Send full application form before 1/1, 4/1, 7/1, 10/1, after initial preliminary application.

3. Carnegie Corporation of New York

Dorothy W. Knapp, Secretary., 437 Madison Ave., New York, NY 10022; (212) 371-3200. Between September 1988 and August 1989 grants were $37,087,461, and 98 reported grants included 5 for meeting general child care problems. Grants are for the diffusion of knowledge and understanding, including the prevention of damage to children particularly from school failure, childhood injury, and substance abuse, as well as early education and child care. No grants to: operating budgets of day care centers or social service agencies, scholarships, deficits, or endowments. Board meets 1, 4, 6, and 10.

4. The Ford Foundation

Barron M. Tenny, Secretary., 320 E. 43rd St., New York, NY 10017; (212) 573-5000. Between September 1988 and August 1989 1,542 grants were $211,769,514, and 156 reported grants included 5 for specific innovative child care programs and policy projects. Grants are for contributions to the solution of national problems, including early childhood education for the urban poor or disadvantaged, as well as the survival and healthy devel-

opment of children. No grants to: programs with readily available substantial support from other sources, religions, operating budgets, undergraduate scholarships, building costs, or personal or local needs. Board meets 3, 6, 9, and 12.

5. Foundation for Child Development

Jane Dustan, VP, 345 E. 46th St., #700, New York, NY 10017; (212) 697-3150. Between March 1988 and February 1989 57 grants were $1,434,547, and 52 reported grants included about 14 for child care initiative in New York City and national child care policy advocacy, policy studies, and research. Grants are currently for children and families at economic and social risk, especially AFDC families adversely affected by the 1988 Family Support Act. No grants to individuals or capital funds, or for direct service projects outside New York City. Board meets 3, 6, 9, and 12.

6. The Harris Foundation

Ruth K. Belzer, Executive Director, 2 N. LaSalle St., #605, Chicago, IL 60602; (312) 621-0566. In 1989, 372 grants were $1,666,077. Grants are for infant mental health and early childhood development. No grants to: individuals, deficits, operating budgets, scholarships, loans, or endowments. Board meets semiannually.

7. Hasbro Children's Foundation

Eve Weiss, Executive Director, 32 W. 23rd St., New York, NY 10010; (212) 645-2400. In 1988, 54 grants were $1,719,843. Grants are for quality of life of children under 12 years, especially health, special needs, abused and neglected children, literacy, homeless children, minority education, and hunger, for national direct service programs. No grants to: operating budgets, individuals, or capital improvements. Deadlines: 12, 4, and 8, with 3 copies of letter and proposal. Board meets 2, 6, and 10.

8. Conrad N. Hilton Foundation

Donald H. Hubbs, President, 100 W. Liberty St., Suite 100, Reno NV 89501; (702) 323-4221. Eighty-six 2/89–2/90 grants were $10,179,630, and 18 reported grants included none for child care; however, the Chronicle of Philanthropy (Biweekly, $60/year; Marion, OH 43305) reported 1 1992 grant for $60,000, "to better coordinate California's existing child care systems in order to improve recruitment, training, and retention of child care professionals." Grants generally are for major long-term projects, including Catholic welfare, and smaller miscellaneous grants. No grants to: religious organizations for their own membership, political activity, local branches of national charities, individuals, loans fundraising events, travel, or surveys. Board meets quarterly.

9. W. K. Kellogg Foundation

Nancy A. Sims, Executive Asstistant—Programming, 1 Michigan Ave. East, Battle Creek, MI 49017-4058; (616) 968-1611. In 1988-1989, 653 grants were $102,400,067, and 109 reported grants included one local grant for child care. The Chronicle of Philanthropy (Biweekly, $60/year; Marion, OH 43305) reported 4 linked 1992 grants for $621,979, "to improve child care through model projects, collaboration with national and international organizations, and a strategic development plan." Grants generally are for pilot projects to improve human well-being. No grants for: research, individuals, capital, endowments, films, equipment, publications, conferences, operating budgets, land, buildings, or loans. Board meets monthly.

10. The J. M. Foundation

Chris K. Olander, Executive Director, 60 E. 42nd St., #1651, New York, NY 10165; (212) 687-7735. 100 1989 grants were $2,290,208, and 9 reported grants included 1 for American Enterprise Institute's child care policy study. Grants are for educational activities that strengthen private enterprise and volunteerism, as well as enhancing the quality of family life, healthy lifestyles and meaningful life experiences and character development for today's youth. No grants to operating expenses, individuals, scholarships, annual fundraising, loans, or endowments. Send summary letter and proposal by 2, 7, or 10, for Board meetings in 5, 10, and 1.

11. Mobil Foundation, Inc.

Richard G. Mund, Secretary., 3225 Gallows Rd., Fairfax, VA 22037; (703) 846-3381. In 1988, 1,001 grants were $9,998,917, and 27 reported grants included 1 for child care advocacy organization. Grants are for community social services where company operates. No grants to: specific disease alleviation, religious or fraternal organizations, individuals, endowments, operating budgets, or events or advertising. Board meets monthly.

12. James C. Penney Foundation, Inc.

Anne L. Romasco, Managing Director, 1633 Broadway, 39th Floor, New York, NY 10019; (212) 830-7490. Fifty 1989 grants were $460,513, and 10 reported grants included 2 for advocacy for better child care. Grants are to empower and benefit economically and politically disadvantaged people, especially through community-based organizations working for social and economic justice in the Northeast and Appalachia. No grants to: individuals, educational institutions, scholarships, research, conferences, or endowments. Board meets three times a year.

13. Smith Richardson Foundation, Inc.

Mrs. Devon Gaffney Cross, Director of Research, 210 E. 86th St., 6th Floor, New York, NY 10028; (212) 861-8181. In 1988, 136 grants were $15,311,787, and 14 reported grants included 4 for general child care policy work. Grants are for early intervention/education projects for at-risk children, and indigenous self-help/mutual aid projects, including child development in economically disadvantaged areas. No grants to: individuals, operating budgets, endowments, loans, or scholarships. Board meets 3, 6, 9, and 12.

14. Rockefeller Family Fund, Inc.

Donald K. Ross, Director, 1290 Ave. of the Americas, Rm. 3450, New York, NY 10104; (212) 373-4252. In 1988, 105 grants were $2,037,414, and 6 reported grants included 3 for child care and staff pay advocacy. Grants are for economic justice for women and advocacy to improve preschool public education, especially for disadvantaged children. No grants to: individuals, deficits, research, scholarships, or endowments. Board meets 6 and 12.

15. The Rockefeller Foundation

Lynda Mullen, Secretary., 1133 Ave. of the Americas, New York, NY 10036; (212) 869-8500. In 1989, 910 grants were $59,966,580, and 114 reported grants included 2 for meeting child care problems for low-income families. Grants are to promote the well-being of mankind. No grants to: cures, inventions, establishment or buildings or budgets of local institutions, profit-making projects, lobbying, individuals, operating budgets, endowments, or scholarships. Board meets usually 3, 6, 9, and 12, and deadlines are specified in individual brochures.

16. Rosenberg Foundation

Kirke Wilson, Executive Director, 210 Post St., San Francisco, CA, 94108; contact (415) 421-6105. In 1988 grants were $1,523,970, and 2 reported grants included 1 for child care tax policy project. Grants are for new/innovative programs benefitting children, especially addressing causes of child poverty and cultural integration, if promoting philanthropy. Grants only for special projects. Board meets six times per year.

17. The Spencer Foundation

Marion M. Faldet, VP, 900 N. Michigan Ave., #2800, Chicago, IL 60611; (312) 337-7000. Between 3/88–2/89 153 grants were $10,686,022, and 16 reported grants included 3 for research on child care issues. Grants are for research in social/behavioral sciences helping education. No grants to: operating support, individuals, scholarships, travel, or endowments. Send three copies of preliminary brief proposal, for Board meetings 1, 4, 7, and 10.

18. Walgreen Corporate Giving Program

Henry Cade, Director, Public Affairs & Professional Relations, 200 Wilmot Rd., Deerfield, IL 60015; (312) 940-2500. In 1988 grants were $2,848,123. Grants are for underprivileged or emotionally disturbed children, primarily in headquarters city and major operating areas. Board meets monthly and as needed.

Funding for Intergenerational Child Care

1. Florence V. Burden Foundation

Barbara R. Greenberg, Executive Director, 630 Fifth Ave., #2900, New York, NY 10111; (212) 332-1150. In 1989 grants were $635,193, and 9 reported grants included 1 for productive employment of older adults in child care. Grants are for problems of aging and violence prevention for young children. No grants to: individuals, endowments, operating expenses, scholarships, or matching gifts. Send letter under five pages, for Board meetings three times per year.

2. The Retirement Research Foundation

Marilyn Hennessy, Senior VP, 1300 W. Higgins Rd., #214, Park Ridge, IL 60068; (708) 823-4133. In 1989 grants were $4,131,981, and 14 reported grants included 1 for intergenerational nursing home/child care center. Grants are for projects to improve the quality of life for older persons. No grants to: recipients outside the Midwest, established organizations' operating funds, individuals, scholarships, conferences, or endowments. Send three copies of proposal by 2/1, 5/1, and 8/1, for Board meetings 4, 7, and 10.

Funding for Buildings and Toys, and In-Kind Materials

1. The Kresge Foundation

Alfred H. Taylor, Jr., Chair, PO Box 3151, Troy, MI 48007; (313) 643-9630. In 1989, 189 grants were $57,533,000, and 29 reported grants included 3 for child care center construction. Challenge grants are for remaining portion of costs of building construction and renovation, major capital equipment or an integrated system, to tax-exempt social services institutions. No grants to: individuals, operating budgets, schools, conferences, scholarships, debt retirement, completed projects, or endowments. Board meets monthly.

2. Tonka Corporate Giving Program

Robert Meek, Director, Corporate Communications, Minnetonka Corporate Center, 6000 Clearwater Dr., Minnetonka, MN 55343;

(612) 936-3393. Grants are for children in need, including toys for tots, annual campaigns, and capital campaigns.

3. National Association for the Exchange of Industrial Resources (NAEIR)

Nancy Roche, Vice President/Marketing, 560 McClure St., PO Box 8076, Galesburg, IL 61402; (800) 562-0955. NAEIR is a nonprofit membership organization of about 7,000 members, with annual dues of $595 plus $50 initiation fee, that solicits, stores, and distributes contributions of new, first quality merchandise from American corporations free to tax-exempt §501(c)(3) schools and nonprofit organizations. First year's dues may be refunded if the member doesn't receive twice annual cost in first year. Members receive annually an average of $7,000 in office supplies, electronics/computer supplies, tools, arts & crafts, toys and activity items for children, janitorial/maintenance supplies, books, wall coverings, furniture, electrical/plumbing fixtures, clothing, etc., for only the cost of shipping and handling.

Funding for Religious Child Care Programs

1. Horace W. Goldsmith Foundation

Robert R. Slaughter, Chief Executive, c/o White & Case, 1155 Ave. of the Americas, New York, NY 10036; (212) 819-8580. In 1989, 266 grants were $11,155,225, and 15 reported grants included 2 for child care centers. Grants are for Jewish welfare funds and education, primarily in New York, Massachusetts, and Arizona. No grants to individuals. Foundation initiates own grants, and Board meets 8 times a year. Do not apply for grants.

2. Koch Foundation, Inc.

Richard A. DeGraff, Executive Director, 2830 N. W. 41st St., #H, Gainesville, FL, 32606; (904) 373-7491. In 1988–1989, 220 grants were $4,689,200, and 16 reported grants included 1 for child care center construction. Grants are for Roman Catholic Church capital and current expenses. No grants to: deficits, individuals, scholarships, or endowments. Deadline: 12/1, and Board meets 9 and 2.

3. Raskob Foundation for Catholic Activities, Inc.

Gerard S. Garey, President, P.O. Box 4019, Wilmington, DE, 19807; (302) 655-4440. In 1989, 575 grants were $3,572,594, and 45 reported grants included 1 for child care. Grants are for second half of costs of Roman Catholic Church activities, including building construction, education and social services. No grants to: individuals, annual budgets, scholarships, or endow-

ments. Send application form by deadlines: 2/15 and 8/15, for Board meetings in the Spring and Fall.

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SUGGESTIONS FOR FURTHER READING

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APPENDIXES

APPENDIX A

NATIONAL ASSOCIATION OF CHILD CARE RESOURCE AND REFERRAL AGENCIES (NACCRRA)

NACCRRA ADDRESS LIST

State	Agency	Address	Full City	Phone
AK	Alaska CCR 7 R Alliance/C.C. Connection	PO Box 103394	Anchorage, AK 95510	907-279-5024
AL	Alabama Assoc. for CCR&R Agencies	1904 First Avenue North	Burmingham, AL 35203	205-252-1991x301
AR	Arkansas Child Care Resource Center	101 East Capitol/Suite 106	Little Rock, AR 72201	501-682-4892
AZ	Tucson Association for Child Care	1030 N. Alvernon Way	Tucson, AZ 85711	602-881-8940
CA	CA CCR&R Network	111 New Montgomery, 7th Fl.	San Francisco, CA 94105	415-9882-0214
CO	CO Office of R&R Agencies	7853 East Arapahoe Road, Suite 3300	Englewood, CO 80112	303-290-9088
CT	United Way of Connecticut/Infoline	900 Asylum Avenue	Hartford, Ct 06105	203-249-6850
DC	Washington Child Development Council	2121 Decatur Place NW	Washington, DC 20008	202-387-0002
DE	Child Care Connection	3511 Silverside Rd, Wilson Bldg #100	Wilmington, DE 19810-4811	302-479-1679
FL	Florida Children's Forum	1282 Paul Russell Road	Tallahassee, FL 32301	904-656-2272
GA	Georgia Association of CCR&R	1447 Peachtree St. NE, Suite 700	Atlanta, GA 30309	404-870-3193
HI	PATCH	810 A Vineyard Blvd	Honolulu, HI 96817	808-842-3874
IA	IA Commission on Child, Youth & Fam.	DHS/Hoover State Office Building	Des Moines, IA 50319-0114	515-281-5583
ID	Child Care Connections	P. O. Box 6756	Boise, ID 83707	208-343-5437
IL	IL CCR&R System	100 W. Randolph, Suite 6-206	Chicago, IL 60601	312-793-5641
IL	Day Care Action Council	4753 N. Broadway St. #726	Chicago, IL 60640	312-561-7900
IN	Indiana Association for CCR&R Agencies	P. O. Box 40725	Indianapolis, IN 46240-0725	317-251-0260
KS	KS Assoc. of CCR&R Agencies	1069 Parklane	Wichita, KS 67218	316-682-1853
KS	Heart of America Family Services	3217 Broadway	Kansas City, KS 66101	913-342-1110
KY	Child Care Council of KY	880 Sparta Court, #100	Lexington, KY 40504	606-254-9176
LA	Child Care Info, Inc.	38657 Plaza Tower Drive	Baton Rouge, LA 70816	504-293-8523
MA	MA CCR&R Network	100 Grove Street, Suite 102	Worcester, MA 01605	508-757-1503
MD	Maryland Child Care Resource Network	608 Water Street	Baltimore, MD 21202	410-752-7588
ME	Maine Assoc. of CCR&R Agencies	44 Water Street	Brunswick, ME 04011	207-725-6506
MI	Michigan 4C Association	2875 Northwind Drive, #200	East Lansing, MI 48823	517-351-4171
MN	Minnesota CCR&R Network	2116 Campus Drive SE	Rochester, MN 55904	507-287-2497

State	Agency	Address	Full City	Phone
MS	Office for Children & Youth	421 W. Pascagoula Street	Jackson, MS 39203	601-949-2054
MT	MSU Early Childhood Project	Herrick Hall	Bozeman, MT 59717	406-994-4746
NC	President, NC R&R Network	P.O. Box 250	Webster, NC 28788	704-586-4039
NC	North Carolina CCR&R Network	700 Kenilworth Avenue	Charlotte, NC 28204	704-376-6697
ND	ND Early Childhood Training Center	P. O. Box 5057, ND State Univ.	Fargo, ND 58105	701-237-8289
NE	Midwest Child Care Assoc.	5015 Dodge #2	Omaha, NE 68132	402-551-2379
NH	NH Assoc. of CCR&R agencies	99 Hanover Street, P.O. Box 448	Manchester, NH 03105	603-668-1920
NJ	CC Operations/Div. of Fam. Assistance	Department of Human Services	Trenton, NJ 08625	609-588-2159
NM	Las Cruces CCR&R	NMSU, Box 3 Cur	Las Cruces, NM 88003	505-646-1165
NV	Child Care Resource Council	1090 S. Rock Boulevard	Reno, NV 89502	702-785-4200
NY	NY State Child Care Coordination Council	237 Bradford Street	Albany, NY 12206	518-463-8663
OH	Ohio CCR&R Association	78 Jefferson Avenue	Columbus, OH 43215	614-224-0222
OK	Child Care Resource Center	2819 S. New Haven	Tulsa, OK 74114-5937	918-747-1985
OR	Oregon CCR&R Network/CCIS	1900 Front Street NE	Salem, OR 97303	503-375-2644
PA	PA Assoc. of Child Care Agencies	2929 N. Front Street	Harrisburgh, PA 17110	717-236-0458
RI	Options for Working Parents	30 Exchange Terrace, Commerce Center	Providence, RI 02903	401-272-7510
SC	State Network in South Carolina	P. O. Box 8821	Greenville, SC 29604-8821	803-455-8320
SD	Family Resource Network	Box 2218/HDCFS/SD State Univ.	Brookings, SD 57007	605-688-6281
TN	TN CCR&R Services	Citizens Plaza, 14th Fl/400 Deaderick	Nashville, TN 37248-9600	615-741-0290
TX	TACCRRA, c/o Austin Families	3307 Northland Drive, #460	Austin, TX 78731	512-454-4732
UT	Utah Office of Child Care	324 S. State Street, #500	Salt Lake City, UT	801-538-8733
VA	VA Child Care Resource & Referral Network	5001 West Broad Street, Suite 301	Richmond, VA 23230	804-282-6131
VT	VACCRRA	Early Childhood Prgms/Vermont College	Montpelier, VT 05602	802-828-8771
WA	WA State CCR&R Network	917 Pacific Ave., #301	Tacoma, WA 98402-4421	206-383-1735
WI	WI C. C. Improvement Project	202 S. Dakota Ave., Box 269	Hayward, WI 54843	715-634-3905
WV	Central Child Care of WV, Inc.	1204 Virginia Street East	Charleston, WV 25301	304-340-3667
WY	Care Connections, Inc.	808 East "A" Street	Casper, WY 82601-2008	307-472-5535

BEST COPY AVAILABLE

APPENDIX B

■

NATIONAL ORGANIZATIONS AND RESOURCES

CAROL ANN BAGLIN

Administration for Children, Youth, and Families
U.S. Department of Health and Human Services
330 C Street, SW
Washington, DC 20201
(202) 205-8347

This agency provides assistance to state and local agencies administering federally funded programs for children, youth, and families. Information is available to the general public including parents and advocates. Assistance is provided to local communities in the development of family services, particularly collaborative efforts with the private sector.

American Academy of Pediatrics
141 Northwest Point Boulevard, Box 927
Elk Grove Village, IL 60009-0927
(708) 228-5005

Representing pediatricians, the Academy works to promote greater access to children's health care, research, and services to children to promote physical, mental, and social-emotional health.

The American Council of Nanny Schools
Delta College (Joy Shelton, President)
University Center, MI 48710
(517) 686-9417

Nonprofit coalition of accredited nanny schools. Administers a competency test for nannies and publishes a directory of accredited schools. Establishes educational standards and provides professional support for nannies.

American Montessori Society
150th 5th Avenue, Suite 203
New York, NY 10011
(212) 924-3209

Promotes the application of Montessori principles and teaching methods to early childhood education. Services provided include a range of specially designed Montessori resources and extensive publications. Focuses on individual growth and peer stimulation among young children, with the teacher as observer.

Americans with Disabilities
U.S. Department of Justice
Civil Rights Division

P.O. Box 66118
Washington, DC 20035-6118
(202) 514-0301
(202) 514-0381 (TDD)

Information is available concerning the Americans with Disabilities Act (ADA). This is the federal agency responsible for interpreting the applicability of the Americans with Disabilities Act, including who is eligible and what constitutes reasonable accommodations.

American Public Health Association
1015 Fifteenth Street, NW
Washington, DC 20005
(202) 789-5600

Promotes health through information and public awareness. Provides training and technical assistance.

American Red Cross
431 18th Street, NW
Washington, DC 20006
(202) 737-8300 Public Inquiry (202) 639-3146

Provides wide range of health related services. Courses are available in infant and child CPR and child care. Local chapters are located within local communities. Extensive publications and resources are available.

Association for the Care of Children's Health
7910 Woodmont Avenue, Suite 300
Bethesda, MD 20814
(301) 654-6549

Ensures that all aspects of children's health are family centered, psychosocially sound, and developmentally supportive. ACCH publishes educational resources for professionals, children, and families. Educates and supports members through an annual conference, Children and Hospitals Week, and several award and grant programs.

Association for Childhood Education International
11501 Georgia Avenue, Suite 315
Wheaton, MD 20902
(800) 423-3563

Professional organization for those involved in the education of children from infancy through early adolescense. Addresses issues related to children's rights, childhood education, and

well-being of children. Resources and information on curriculum, teacher preparation, assessment and evaluation, and school and community partnerships with parents. Services include advocacy, conferences, workshops and seminars, as well as publications for consumers and professionals.

Association Montessori International
170 West Schofield Road
Rochester, NY 14617
(716) 544-6709

Dedicated to preserving original Montessori teaching methods in the United States. Promotes training standards and coordinates U.S. activities. Provides members with professional information, publications, consultations, and job information.

Aupair in America
102 Greenwich Avenue
Greenwich, CT 06830
(203) 863-6123/(800) 727-2437

The American Institute for Foreign Study (AIFS) handles placements nationwide. Host families must live near one of the 76 cluster areas.

AuPair Homestay USA
1015 15th Street, NW
Suite 750
Washington, DC 20005
(202) 408-5380

The Experiment in International Living is designated by the U.S. Government as an official au pair sponsor. This program brings young European adults to the United States to live with American families and provide child care services. Since the program began in 1986, AuPair Homestay USA has placed more than 5,000 Europeans au pairs with host families in the United States.

Bank Street College of Education
Family Center
610 West 112th Street
New York, NY 10025
(212) 875-4412

Bank Street College is a graduate school for teachers and administrators in the education of young children. In addition, there is a school for children from 3 months to 3 years of age and a center for child and family research. The Family

Center publishes reports, conducts policy analysis, and provides information and consultation on child care.

Black Child Development Institute
1023 15th Street, NW
Suite 600
Washington, DC 2005
(202) 387-1281

Established in 1970, this organization functions to improve the quality of life for black children. The institute focuses on the many issues of relevance to children and families, including child care, child welfare, health, and quality education. Services at the local level are provided through a network of volunteer chapters.

Centers for Disease Control
U.S. Department of Health and Human Services
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 639-3311

The mission of the Centers for Disease Control (CDC) is to improve the quality of life for all Americans by preventing unnecessary disease, disability, and premature death and by promoting healthy lifestyles. The CDC has a variety of publications related to the management of communicable diseases in group settings for young children. An interagency group has been formed to explore issues related to child care and communicable diseases.

The Child and Adolescent Service System Program (CASSP)
Technical Assistance Center
Suite 215
2233 Wisconsin Ave, NW
Washington, DC 20007
(202) 338-1831

The CASSP is helping states and communities to build systems of care for children and youth with serious emotional disorders and their families.

Child Advocacy Office
National Council of Churches
475 Riverside Drive, Room 572
New York, NY 10115-0050
(212) 870-3342

This Office promotes children's issues through the Ecumenical Child Care Network. Issues such as prevention of child abuse,

liability insurance for child care programs, compensation for child care providers, and quality indicators in child care are brought to the attention of churches and society.

Child Care Action Campaign
17th Floor, Dept. P,
330 Seventh Avenue
New York, NY 10001
(212) 239-0138

Promotes quality child care. Provides information to parents on selecting appropriate child care settings. Lists of Resource and Referral Groups from each state are available. Fact Sheets on child care topics provided.

Child Care Employee Project
PO Box 5603
Berkeley, CA 94705
(510) 653-9889

This advocacy organization promotes the improvement of wages, working conditions, and professional status of child care workers. It provides training, conducts research, publishes education materials, and provides consultation.

Child Care, Inc.
275 Seventh Avenue
New York, NY 10001
(212) 929-7604

Child Care, Inc. is a New York City nonprofit organization which has helped existing neighborhood organizations create new family day care networks. They have development strategies for recruitment and training of child care providers, as well as market techniques for their services.

Child Care Information Exchange
PO Box 2890
Redmond, WA 98073
(206) 883-9394

The Child Care Information Exchange publishes a bimonthly journal designed primarily for child care directors. A variety of issues are addressed in the journal including curriculum, legislative initiatives, child custody conflicts, technology applications in early childhood, and health guidelines for child care centers. Susan Aronson, MD, a consultant on infectious diseases and child care, is a frequent contributor to this publication.

Child Care Law Center
22 2nd Street, 5th floor
San Francisco, CA 94105
(415) 495-5498

This legal services organization works to expand quality, affordable child care for low income families. It provides representation for clients, consultation on legislation, technical assistance, and public education through publications.

Child Development Associate (CDA)
National Credentialing Program
Council for Early Childhood Professional Recognition
1341 G Street, NW
Suite 400
Washington, DC 20005
(202) 265-9090/(800) 424-4310

Initiated in 1971, The Child Development Associate (CDA) Council for Early Childhood Recognition is a national effort to evaluate and improve the skills of caregivers in center-based, family day care and home visitor programs. A Child Development Associate or CDA is a person who has demonstrated competence in caring for young children and is awarded the Child Development Associate Credential.

Child Trends, Inc.
2100 M Street, NW
Washington, DC 20037
(202) 223-6288

Conducts projects related to school readiness, focusing on parental behaviors that reinforce health physical development of infants and young children, studying basic skills training for mothers receiving public assistance, and early childhood assessments in several nations.

Child Welfare League of America
440 First Street, NW, Suite 310
Washington, DC 20001-2085
(202) 638-2952

Voluntary membership organization devoted entirely to protecting and promoting the well-being of troubled children, youths, and their families.

Children's Defense Fund
25 E Street, NW

Washington, DC 20001
(202) 628-8787

Nonprofit organization committed particularly to the needs of poor, minority, and disabled children. Their goal is to educate the nation about the needs of children and encourage preventive investment in children before they get sick, drop out of school, suffer family breakdown, or get into trouble.

The Children's Foundation
725 15th Street, NW
Suite 505
Washington, DC 20005-2109
(202) 347-3300

National organization working to promote family day care and to professionalize the services of providers by offering training and technical assistance to providers and provider support groups.

Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(703) 620-3660

The Council works to improve the quality of education for exceptional children. The organization includes professionals and parents. CEC includes the Center for Special Education Technology, the National Clearinghouse for Professionals in Special Education, and the ERIC Clearinghouse on Handicapped and Gifted Children.

Disability Rights Education Defense Fund
2212 Sixth Street
Berkeley, CA 94710
(800) 466-4232

National law and policy center dedicated to furthering the civil rights of people with disabilities.

Ecumenical Child Care Network
475 Riverside Drive
New York, NY 10115
(212) 870-3342

Targets child care programs which are housed in churches, synagogues and varied other religious facilities. This membership organization of child care programs provides information, publications, and technical assistance.

Educational Home Model Outreach Project
Rural Institute
University of Montana—N. Corbin Hall
Missoula, MT 59812
(406) 243-5467

Promotes the integration of children with disabilities in child care settings by supporting care providers, parents, and community service providers, including social workers, therapists, physicians, teachers, and administrators.

ERIC Clearinghouse on Elementary and Early Childhood Education
University of Illinois
805 West Pennsylvania Avenue
Urbana, IL 61810
(217) 333-1386

ERIC is an information system available nationwide. Information is provided on child development, classroom techniques, special education and teacher education. Document collections are on microfiche in more than 700 libraries.

Family Resource Coalition
200 South Michigan Avenue, Suite 1520
Chicago, IL 60604
(312) 341-0900

National membership organization whose members represent a professionally and culturally diverse network of people committted to providing preventive, community-based services to families and children. These services include information, technical assistance, and training for people involved in this rapidly growing discipline.

The Fatherhood Project
Families and Work Institute
330 Seventh Avenue
New York, NY 10001
(212) 875-4400

This project is designed to encourage greater male involvement in child rearing. Services include publication of a program guide for fathers. In addition, it operates a national clearinghouse on fatherhood and referral to resources for fathers.

Health Information Center
PO Box 1133

Washington, DC 20013-1133
(202) 336-4797/(800) 336-4797

The Office of Disease Prevention and Health Promotion (ODPHP) in the U.S. Public Health Service stimulates and coordinates efforts in both the public and private sectors to reduce the risk of disease and early death to promote good health. Provides publications on health-related topics.

Healthy Mothers, Healthy Babies Coalition
409 12th Street, SW
Washington, DC 20024
(202) 863-2458

Informal association comprised of professional, voluntary, and governmental organizations with a common interest in maternal and infant health. The Coalition fosters education efforts for pregnant women through collaborative activities and sharing of information and resources.

High/Scope Educational Research Foundation
600 North River Street
Ypsilanti, MI 48198-2898
(313) 485-2000

High/Scope conducts research and develops curriculum to develop alternatives to traditional education of children and training of teachers. It analyzes educational programs that work and provides results to teachers and caregivers.

International Nanny Association
Kelly Campbell, President
PO. Box 26522
Austin, Texas 78755
(512) 454-6462
Betty Cass (Nebraska Office) (402) 379-3606

Educational organization for nannies and those who educate, place, employ, and support professional in-home child care providers.

The National Association of Child Care Resource and Referral Agencies (NACCRRA)
2116 Campus Drive SE
Rochester, MN 55904
(507) 287-2220

Instrumental in mobilizing the resources and chart the course for creating a child care and early education system

that works for all parents and children regardless of income or special family circumstance.

National Association of Community Health Centers
1330 New Hampshire Avenue, NW, Suite 122
Washington, DC 20036
(202) 659-8008

Provides technical assistance to member organizations. Disseminates information and publications related to community-based health services.

National Association for the Education Of Young Children
1834 Connecticut Avenue NW
Washington, DC 20009
(800) 424-2460/(202) 232-8777

Monitors child care across the country and can provide information on each state. Dedicated to improving the quality of care and education of children from birth to age 8. Provides publications and videos for parents, child care providers, and school personnel. Administers the National Academy of Early Childhood Programs, a voluntary national accreditation system for early childhood programs.

National Association for Family Day Care
725 15th Street, NW
Washington, DC 20005
(800) 359-3817/(202) 347-3356

A membership association for family and group day care home providers dedicated to supporting the family day care provider and profession.

National Black Child Development Institute, Inc.
1023 15th Street, NW, Suite 600
Washington, DC 20005
(202) 387-1281

Promotes the improvement of the quality of life for black children and youth. Provides information and advocacy on such issues as health, child welfare, education, and child care.

National Center for Clinical Infant Programs, ZERO TO THREE
2000 14th St., N, Suite 380
Arlington, VA 22201-2500
(703) 528-4300 Publication Ordering (800) 544-0155

NCCIP focuses on children from birth to age 3, with the emphasis on social, emotional, physical, and cognitive development. Promotes infant development by emphasizing preven-

tion. NCCIP coordinates research and provides information on clinical infant programs.

National Child Care Association
1029 Railroad Street
Conyers, GA 30207
(800) 543-7161

Promotes quality child care through public information, legislations and regulations, and expansion of private, licensed child care. Provides information about licensed, center-based care.

The National Coalition for Campus Child Care , Inc.
Charles Boulton, Office Manager
PO Box 258
Cascade, WI 53011
(414) 528-7080

Educational and professional organization whose purpose is to promote the existence of quality campus child care programs. It provides annual conferences, publications, and networking.

National Coalition of Hispanic Health and Human Services Organizations
1501 16th Street, NW
Washington, DC 20036
(202) 387-5000

Offers publications on health issues specifically for the Hispanic community. Conducts research and promotes services for health issues.

National Commission to Prevent Infant Mortality
Switzer Building, Room 2014
330 C Street, SW
Washington, DC 20201
(202) 205-8364

Promotes awareness of the problem of infant mortality and its causes. Distributes a resource directory of organization solely dealing with infant mortality, entitled A Resource Directory.

National Early Childhood Technical Assistance System (NEC*TAS)
NationsBank Plaza
137 E. Franklin Street
Chapel Hill, NC 27514
(919) 962-2001

Funded by the U.S. Department of Education, Office of Special Education and Rehabilitation Services. Assists states and other designated governing jurisdictions as they develop mul-

tidisciplinary, coordinated, culturally sensitive, and comprehensive services for children with special needs, birth through age 8 years, and their families.

National Head Start Association
201 North Union Street, Suite 320
Alexandria, VA 22314
(703) 739-0875

Seeks to improve the quality and quantity of Head Start programs and services. Conducts training sessions and seminars, develops and disseminates policies and Head Start related positions, and advocates for improved services for Head Start programs.

National Information Center for Children and Youth with Disabilities (NICHCY)
P.O. Box 1492
Washington, DC 20013
(800) 999-5599/(703) 893-6061

Disseminates information related to children and youth with disabilities to parents, educators, caregivers, advocates, and others to help children with disabilities. Maintains databases with information on disability topics. Promotes community integration of disabled children. Free publications available.

National Jewish Early Childhood Network
6505 Wilshire Boulevard, Suite 710
Los Angeles, CA 90048
(213) 852-1234
(818) 990-8640

Provides a support system for resources, curriculum ideas, and philosophical approaches for Jewish families, including religious and secular educators.

National Maternal and Child Health Clearinghouse
8201 Greensboro Drive, Suite 600
McLean, VA 22102
(703) 821-8955 x254

Developed to provide education and information services in maternal and child health. Funded by the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services.

National Parent Network on Disabilities
1600 Prince Street

Suite 115
Alexandria, VA 22314
(703) 684-6763

Shares information and resources. Includes parent organizations, parents, and advocates of children and youth. Provides up-to-date reporting on governmental policy and links parents organizations.

National SAFE KIDS Campaign
111 Michigan Avenue, NW
Washington, DC 20010
(202) 939-4993

Promotes community education and informational campaigns to prevent unintentional injuries to children. State and local offices have information and material.

Parents as Teachers (PAT) National Center
9374 Olive Boulevard
St. Louis, MO 63132
(314) 432-4330

Encourages parents of children, birth to age 3, to think of themselves as their child's first teacher. Provides information and parent training, supports policy initiatives, and offers parent educator certification.

Work/Family Directions, Inc.
930 Commonwealth Avenue, West
Boston, MA 02215
(617) 278-4206

A human resources consulting form that assists companies in helping their employees to be productive at work while fulfilling their family responsibilities.

APPENDIX C

ANNOTATED BIBLIOGRAPHY OF RESOURCES

KIMBERLY McCREA

BOOKS

American Public Health Association. (1992). *Caring for our children, national health and safety performance standards: Guidelines for out-of-home child care programs.* Ann Arbor, MI: Edwards Brothers.

Provides a comprehensive guide to many questions parents have about day care centers. National standards are given for staffing ratios, infectious diseases, administration issues, record keeping, and many other issues.

Brazelton, T. Berry. (1989). *Families crisis and caring.* New York: Addsion-Wesley Publishing Company, Inc.

Details the lives of five real families, how crisis upsets the stability of a family, and how each member copes with the problem and ultimately regains balance and grows from the experience. This book provides hope and strength to readers.

Child Welfare League of America. (1991). *CWLA standards of excellence for child day care service.* Washington, DC: Child Welfare League of America.

Dodge, D. T., Dombro, A. L., & Koralek, D. G. (1991). *Caring for infants and toddlers: A supervised, self-instructional training program volume I.* Washington, DC: Teaching Strategies, Inc.

Dodge, D. T. & Colker, L. J. (1991). *Creative curriculum for family child care.* Washington, DC: Teachers Strategies, Inc.

Offers concrete approaches and strategies for implementing appropriate in-home child care programs. The book is divided into two parts, setting the stage and activities.

Edelman, M. E. (1992). *The measure of our success: A letter to my children and yours.* Washington, DC: Children's Defense Fund.

For anyone who cares for children, whether parent, teacher, or caregiver this book is food for thought. Share the vision of M. W. Edelman, founder and President of the Children's Defense Fund, and be supported for caring so passionately about how our children are raised.

Garcia, R. (1991). *Home-centered care: Designing a family day care program.* Mt. Rainer, MD: Gryphon House.

Introduces strategies for operating a family day care and explores possible challenges, including designing a physically safe environment, attending to children's needs and likes, understanding and meeting child care standards, and practical application of child development concepts.

Gillis, J., & Fise, M. E. (1990). *Childwise catalog: A consumer guide to buying the safest and best products for your children.* New York: Harper & Row.

Provides consumer information for a vast variety of items and services for children, from unsafe toys and health foods to adoption services and car seats.

Honig, A. & Lally, J. R. (1981). *Infant cargiving: A design for training.* Syracuse, NY: Syracuse University Press.

Jacob, S. H. (1991). *Your baby's mind: How to make the most of the critical first two years.* Holbrook, MA: Bob Adaams, Inc Publishers.

Offers a balanced and accessible program for infant development based on the six recognized stages of early intellectual growth. Meaningful interactions between parent and child are stressed as opposed to rote learning.

Klass, C. S. (1986). *The autonomous child: Day care and the transmission of values.* Philadelphia, PA: Falmer Press.

Studies whether the social childrearing context of day care transmits to young children values different from those within America's dominant value tradition of individualism.. Displays actions and words of day care teachers and children in their daily activities.

Kontos, S. (1992) *Family day care: Out of the shadow and into the limelight.* Washington, DC: National Association for the Education of Young Children.

Leavitt, R. L., & Eheart, B. K. (1985). *Toddler day care a guide to responsive caregiving.* Lexington, MA: Lexington Books.

Exhilarating, challenging, and sometimes exhausting—toddlers! This excellent book provides a look at the uniqueness of this phase of childhood, developmental information, practical tips on guiding behavior, arranging the physical environment, daily schedules, health and safety, and concerns of parents.

Maynard, F. (1985). Child care crisis: The real costs of day care for you and your child. New York: Viking.

Examines forms of child care, from day care centers to home care, from baby-sitters to nannies, to determine a relationship between day care and continuity of American values.

Miller, D. (1989). *First steps toward cultural difference: Socialization in infant/toddler day care.* Washington: Child Welfare League of America.

Provides a sociological viewpoint on day care by utilizing studies of the staff-child relationships in several day care settings. This study tries to clarify how and why different kinds of families hold divergent views on what constitutes good and proper child care.

Morgan, G. G. (1982). *Managing the day care dollars: A financial handbook.* Cambridge, MA: Steam Press.

Basic financial concepts are clearly and simply explained in this book, including the budget as policy, financial planning, cash flow analysis, breaking even, and accounting. Dozens of sample reports and ready-to-use worksheets and checklists are included.

Muscari, A., & Morrone, W. W. (1989). *Child care that works: How families can share their lives with child care and thrive.* New York: Doubleday.

Offers poignant discussions and answers to the child care dilemmas parents face. Also provides parents with child care options.

Pressman, D., & Emery, L. J. (1991). *Serving children with HIV infection in child day care: A guide for center-based and family day care providers.* Washington, DC: Child Welfare League of America.

Addresses issues related to providing child care to HIV-infected children, including policy and procedure, medical and psychosocial issues, and advocacy groups.

Provence, S. (1967) *Guide for the care of infants in groups.* Washington, DC: Child Welfare League of America.

Provides guidelines to help meet the emotional, social, and developmental needs of infants in child care groups.

Roby, P. (1973). *Child care—who cares?: Foreign and domestic infant and early childhood development policies.* New York: Basic Book, Inc.

Provides a look at issues that were current 20 years ago and indicates similarities to this decades' problems in child care.

Scairra, D. J., & Dorsey, A. (1990). *Developing and administering child care center, 2nd.* Albany, NY: Delmar Publishing Inc.

Focuses on comprehensive treatment of child care administration detailing the information involved in start-up and day-to-day operation of a child care center. Information is provided on assessing your community's needs, getting licensed, and motivating workers.

Shelov, S., & Hannemann, R., et. al. (1992). *Caring for your baby and young child: Birth to age 5.* Elk Grove Village, IL: American Academy of Pediatrics.

The first section of this guide is a parenting manual covering topics ranging from preparing for childbirth and choosing a pediatrician to bonding and basic child care. The second section is devoted to recognizing and dealing with health prolems ranging from common infectious diseases to developmental disabilities and chronic conditions.

Shelov, S., & Hannemann, R., et. al. (1992). *Caring for your school-age child: Age 5-12.* Elk Grove Village, IL: American Academy of Pediatrics.

Provides resources to guide parents through the crucial years from the start of school to the onset of adolescence, a comprehensive health reference and a complete guide to the complex developmental issues of the middle years.

Spaide, D. (1990). *Day care kit.* New York: Birch Lane Press Books.

Provides realistic alternatives to parents of unborn, newborn, or preschool children seeking day care information. Guidelines are given for evaluating day care centers, initiating day care at work, and a host of other topics.

Sugarman, J. M. (1991). *Building early childhood systems: A resource handbook.* Washington, DC: Child Welfare League of America.

Explains state funding of early childhood systems, how the laws work, and how states and local communities can build workable systems.

Vogel, S. N. & Manhoff, D. (1989). *Emergency medical treatment: Infants.* Wilmette, IL: EMT, Inc.

Provides easy-to-understand, step-by-step, illustrated instructions to 15 of the most common infant life-threatening emergencies.

Wheat, R. (1989). *Diversity in day care: Options and issues.* Lancaster, PA: Technomic Publishing Company, Inc.

The growing need for day care, changing roles of day care, community child care, and quality of family life are a few topics discussed in this book.

Whitebook, M., Howes, C. J., & Phillips, D. (1989). *Who cares? Child care teachers and the quality of care in America: Executive summary of the national child care staffing study.* Oakland, CA: Child Care Employees Project.

Zigler, E. F., & Lang, M. E. (1991). *Child care choices: Balancing the needs of children, families and society.* New York: Free Press.

Provides analyses of historical and cross-cultural perspectives of child care and identifies successess and failures of the child care system.

JOURNALS AND MAGAZINES

Atkinson, A. M. (1992). Stress level of family day care providers, mothers employed outside the home, and mothers at home. *Journal of Marriage & the Family, 54* (2), 379–386.

Individual and family variables were compared between mothers who are family day care providers, mothers employed outside the home, and mothers not employed. Significant differences were found for mothers' level of stress, education, income and work hours, for some aspects concerning husbands, and for some concerning a number of children.

Howes, C., Phillips, D. S., & Whitebook, M. (1992). Thresholds of quality: Implications for the social development of children in center-based child care. *Child Development, 63* (2), 449–460.

Assessment of relationships between young children in child care settings and their peers and adults.

Johnson, C. (1992). Save the children. *New Woman, 22* (2), 60–65.

Many mothers face a major dilemma when it comes to returning to work or staying home, but often financial and psychological reasons lead to the decision of working and finding outside day care. Since a commitment to children should remain our first priority, an evaluation of current day care, fatherhood, and careers is discussed.

Kate, N. T. (1992). Filling the corporate day-care gap. *American Demographics, 14* (1), 19–20.

Examines the issue of day care providers targeting corporations for business instead of parents.

Murray, K. A. (1985). Child care and the law. *Santa Clara Law Review, 5* (2–3), 290–302.

Provides a historical perspective on funding trends in child care.

Pizzo, P. D. (1990). Whole babies, parents, and pieces of fund: Creating comprehensive programs for infants and toddlers. *Zero to Three, XI* (3) 24–28.

Summarizes federal programs that provide resources for providers of services to infants and toddlers.

Pond-Smith, D., Richarz, S. H., & Gonzalez, N. L. (1992). A survey of foodservice operations in child care centers in Washington State. *Journal of the American Dietetic Association, 92* (4), 483–484.

Licensed, full-day care centers in Washington State were surveyed to gain more information about foodservice operations.

Stern, L. (1992). Your child's health: Keeping day care healthy. *Womans's Day, 55* (10), 22.

Offers suggestions on choosing healthy child care outside of the home.

VIDEOS

Filstrup, J. M., & Gross, D. W. (1982). *Monday through Friday day care alternatives.* New York: Teachers College Press.

Nine families share how they are responding to needs for outside assistance in child care. Through interviews these families show that there are many forms day care can take.

Kendrick, A., & Gravell, J. (1990). *Family child care, health, and safety.* St. Paul, MN: Redleaf Press.

This 18-minute cassette focuses and explores issues parents and children face on health, safety, and child care.

Choosing quality childcare. (1991). Hayward, WI: Wisconsin Child Care Improvement Project.

This 20-minute videotape presents and discusses guidlines and qualities to look for when choosing and evaluating child care centers.

Selecting day care for your child. (1991). Danielsville, GA: Dan Sperling Video & Film Productions, Inc.

There are numerous questions that should be considered before placing a child in day care. This 70-minute videotape has been professionally developed for parents, consumers, child care associations, and classroom instruction. A checklist is included for help in considering all options before interviewing prospective day dare facilities for your child.

Mister Rogers talks with parents about day care. (1992). Alexandria, VA: PBS Video.

When parents work, day care often becomes a major part of the family routine. Fred Rogers explores some of the rewards, difficulties, and feelings associated with this subject. This 28-minute videotape stresses the importance of parent-provider partnerships.

Sperling Video & Film Production, Inc. (1991). *Selecting day care for your child.* Washington, DC: Child Welfare League of America.

EVALUATIONS

Harms, T., Cryer, D., & Clifford, R. (1990). *Infant/toddler environment rating scale*. New York: Teachers College Press.

Provides 35 assessment items focusing on infants and toddlers to aid in the quest for high-quality day care.

Southeastern Day Care Project. (1980). *Evaluating children's progress: A rating scale for children in day care*. Atlanta, GA: Save the Children Foundation.

Progress evaluation of children in day care centers and family day care homes is the focus of this document. Standardized items for children from infancy through five years are used in this rating scale. The scale can be administered by day care staff and provides immediate feedback.

BIBLIOGRAPHIES

Howes, C. (1986). *Keeping current in child care research: An annotated bibliography*. Washington, DC: National Association for the Education of Young Children.

Honig, A. S. (1988). *Infant/toddler caregiving: An annotated guide to media training materials*. San Francisco, CA: Far West Laboratory for Educational Research and Development.

Human Resources Division. (1989). *Child care: Selected bibliography*. Washington, DC: United States General Accounting Office.

APPENDIX D

DIRECTORY TO FEDERAL PROGRAMS

JOHN SURR

(These listings are alphabetically arranged by program title as it appears in Chapter 8, with the number appearing first.)

Program	Department	Office	Phone
11.j.Adoptive Parents Respite Care	HHS	Administration for Children & Families	(202) 205-8671
36.b.Aid to Families with Dependent Children	HHS	Administration for Children & Families, Office of Family Assistance	(202) 401-9294
11.h.Appalachian Economic & Human Resources Development Program	Appalachian Regional Commiss.	Executive Director's Office	(202) 673-7874
11.k.Bilingual Education Programs	Education	Office of Bilingual Education & Minority Languages Affairs	(202) 205-5463
21.CDA Scholarship Assistance	HHS	Administration for Children, Youth & Families, Head Start Office	(202) 205-8347
5.Chapter I Preschool Education	Education	Office of Elementary & Secondary Education, Compensatory Education Programs	(202) 401-1682
26.a.Child Abuse & Neglect Prevention Grants	HHS	Administration for Children & Families, Children's Bureau, National Center on Child Abuse & Neglect	(202) 205-8910
39.a.Child & Dependent Care Tax Credit	Treasury	Internal Revenue Service	(800) 829-4477 (800) 829-1040 (800) 424-FORM
2,12,20,28. Child Care and Development Block Grant	HHS	Administration for Children & Families, CCDBG Division	(202) 401-9326

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Program	Department	Office	Phone
29.Child Care Food Program	Agriculture	Food & Nutrition Service	(703) 756-3947
33.Child Care in Federal Buildings	General Services Administration	Office of Child Care & Development Programs	(202) 501-3965
8.Child Care in Military Installations	Defense	Office of Family Policy Support and Services	(703) 696-4555
9.Children with Disabilities	Education	Office of Special Education Programs, Division of Educational Services	(202) 205-8498
18.a.Child Welfare Research & Demonstration Projects	HHS	Administration for Children & Families, Children's Bureau	(202) 205-8588
18.b.Child Welfare Service Grants	HHS	Administration for Children & Families, Children's Bureau	(202) 205-8740
35.Clearing House on Work & Family Issues	Labor	Women's Bureau	(202) 523-4486
7.Comprehensive Child Development Centers Act	HHS	Office of Human Development Services	(202) 205-8566
18.d.Community-Based Integration Projects	HHS	Assistant Secretary for Planning & Evaluation	(202) 690-7858
18.c.Community Development Block Grant	Housing & Urban Development	Office of Block Grant Assistance, Community Planning & Development	(202) 708-3587
11.f.Consumer & Home Economics Program	Education	Office of Vocational & Adult Education, Division of Vocational-Technical Education	(202) 205-5421
14,25.Dependent Care & Development Block Grant	HHS	Administration for Children, Youth & Families	(202) 205-8034

Program	Department	Office	Phone
11.c.Dislocated Workers Program	Labor	Employment Training Administration	(202) 535-0305
23.a.Early Childhood Staff Training & Professional Enhancement Grants	Education	Office of Post-Secondary Education	(202) 708-9069
23.b.Early Childhood Teacher Training, & Violence Counseling	Education	Office of Post-Secondary Education	(202) 708-9069
16.Early Education for Children with Disabilities	Education	Office of Special Education Programs, Division of Educational Services	(202) 205-9084
40.Earned Income Tax Credit	Treasury	Internal Revenue Service	(800) 829-4477 (800) 829-1040 (800) 424-FORM
39.b.Employer-Provided Child Care Services or Allowances	Treasury	Internal Revenue Service	(800) 829-4477 (800) 829-1040 (800) 424-FORM
6.Even Start Family Literacy Program	Education	Office of Elementary & Secondary Education, Division of Program Support	(202) 401-0716
25.Foster Grandparents Program	ACTION		(202) 606-4849
37.d.Guaranteed Student Loan Program	Education	Office of Fedral Student Aid Programs	(202) 708-9776
1.Head Start	HHS	Administration for Children, Youth & Families, Head Start Office	(202) 205-8539

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Program	Department	Office	Phone
23.Higher Education Act	Education	Office of Post-Secondary Education	(202) 708-9069
37.f.Income-Contingent Loan Program	Education	Office of Post-Secondary Education, Student Financial Assistance Programs, Campus-Based Programs, Policy Secondary	(202) 708-4690
11.i.Indian	Interior	Bureau of Indian Affairs, Division of Social Services	(202) 208-2721
34.Inexpensive Book Distribution Program	Education	Division of Formula Grants	(202) 401-1059
11.a.Job Corps Labor	Labor	Office of Job Training	(202) 523-6871
11.b.Job Training Partnership Act	Labor	Employment Training Administration; Title II-A Employment Training Administration; Title IV	(202) 523-6871 (202) 523-6871
15.Medicaid Reimbursements	HHS	Health Financing Administration, Office of Prepaid Health Care	(202) 619-0815
11.l.Native Hawaiian Education Assistance Programs	Education	Office of Elementary and Secondary Education, Division of Discretionary Grants	(202) 401-0113
38.Non-Profit Child Care Center Exemption	Treasury	Internal Revenue Service	(800) 829-4477 (800) 829-1040 (800) 424-FORM
23.d.Paul Douglas Teacher Scholarships	Education	Office of Post-Secondary Education Division of Higher Education Programs	(202) 708-9453
37.a.Pell Grants	Education	Office of Post-Secondary Education, Student Financial Assistant Programs, Campus-Based Programs, Policy Secondary	(800) 4-FEDAID

Program	Department	Office	Phone
37.e.Perkins Loan Program	Education	Office of Post-Secondary Education, Student Financial Assistant Programs, Campus-Based Programs, Policy Secondary	(800) 4-FEDAID
36.c.Public & Indian Housing Program	HUD		(202) 708-1015
17.Public Housing Child Care Demonstration Program	HUD	Office of Resident Initiatives, Economic Development & Supportive Services Division	(202) 708-4214
34A.Ready to Learn Act	Educ.	Office of Educational Research/Information	(202) 219-2164
11.g.Resident Manager Program	HUD	Office of Resident Initiatives	(202) 708-3611
36.c.Section 8 Housing Program	HUD		(202) 708-4579
13.Small Business Loan Program	Small Business Administration	contact nearest SBA office	(local contact)
11.m.Special Child Care Services for Disadvantaged Coll. Students	Education	Office of Post-Secondary Education	(202) 708-9069
24.Special Education Training Grants	Education	Office of Assistant Secretary for Special Education & Rehabilitation Services, Division of Personnel Preparation, Special Education Programs	(202) 205-9554
30.Special Milk Program	Agriculture	Food & Nutrition Service	(703) 756-3590
31.Summer Food Service Program	Agriculture	Food & Nutrition Service	(703) 756-3590
37.b.Supplemental Education Opportunity Grants	Education	Office of Post-Secondary Education, Student Financial Assistant Programs, Campus-Based Programs, Policy Secondary	(800) 433-3243

(continued)

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Program	Department	Office	Phone
32.Surplus Property Disposal	General Services Administration	Federal Supply Service	(703) 557-1234
36.c.State Student Incentive Grant Program	Education	Office of Post-Secondary Education, Student Financial Assistant Programs,Campus-Based Programs, Policy Secondary	(800) 333-4636
23.c.Teacher Corps	Education	Office of Post-Secondary Education, Student Financial Assistant Programs	(202) 708-7389
10.Temporary Child Care for Children with Disabilities	HHS	Administration for Children & Families, Children's Bureau, Division of Child Welfare	(202) 205-8899
3.3A,3B,11.e,19, 22.Title IV-A Child Care	HHS	Administration for Children & Families, Office of Family Assistance	(202) 401-9294
19,22.b.Title IV-A Child Care Improvement Grants	HHS	Administration for Children & Families, Office of Family Assistance	(202) 401-5065
4.Title XX Social Services Block Grant	HHS	Administration for Children & Families, Office of Human Development Services	(202) 690-7978
26.b.Vocational Education Act	Education	Office of Assistant Secondary for Vocational & Adult Education, Division of Vocational-Technical Education	(202) 205-5421
11.e.Workplace Literacy Partnership	Education	Office of Assistant Secondary for Vocational & Adult Education, Division of Vocational-Technical Education	(202) 205-5421
37.g.Work-Study Program Education	Education	Office of Post-Secondary Education, Student Financial Assistant Programs, Campus-Based Programs, Policy Secondary	(202) 708-4690

APPENDIX E

ANNOTATED FUNDING RESOURCES

JOHN SURR

A. FEDERAL PROGRAMS

1. Helen Blank for Children's Defense Fund, *The Child Care and Development Block Grant and Child Care Grants to States under Title IV-A of the Social Security Act*, 1991, Appendix Table. This 21-page table compares the main features of the Child Care and Development Block Grant, the Title IV-A At Risk Grants, the Title IV-A Transitional Grants, the Title IV-A JOBS program, and the Title XX Social Services Block Grant.

2. Eden Fisher Durbin et al., for Child Welfare League of America, *Funding for Child Care Training: A Federal Yellow Pages*, 1990. This 68-page book provides an annotated listing of the numerous federal programs that may be of assistance in supporting the training of child care professionals, as well as a chart of state allocations for 14 programs. It is detailed and helpful concerning federal financial resources for training.

3. Gwen Morgan for National Association of Child Care Resource and Referral Agencies (NACCRRA), *A Hitchhiker's Guide to the Child Care Universe*, 1991, pages 44–51: "Sources of Federal Funds for Early Care and Education Programs." The principal programs are described and analyzed individually and as to their combined effect. A thoughtful analysis of the effect of the federal government on child care generally.

4. Kathleen A. Murray, "Child Care and the Law," in *Santa Clara Law Review* (Vol. 25, No. 2-3, Spring-Summer 1985), pages 290–302. This article, and another article by Erica B. Grubb in the same issue, are dated but useful in gaining a historical perspective on trends in funding.

5. Peggy Daly Pizzo, "Whole Babies, Parents, and Pieces of Funds: Creating Comprehensive Programs for Infants and Toddlers," *Zero to Three*, (National Center for Clinical Infant Programs, February 1990, pages 24–28). This article summarizes the federal programs that provide resources for providers of services to infants and toddlers, and emphasizes the "whole baby" and family centered approaches to piecing together a variety of sources of funding. Medicaid and the Children with Disabilities programs are fully described in this article.

6. U.S. Department of Education, *Guide to U. S. Department of Education Programs*, 1991, (U.S. General Printing Office, Publication No. 1991 O - 293-696: QL 3), 73 pages. This publication summarizes, by administering office, the funding programs administered in 1991 by the Department of Education. It is somewhat similar to this Appendix in providing brief program descriptions and contact phone numbers, and it has an

index. The programs supporting child care are not indexed separately or described.

7. U.S. Department of Health and Human Services and MAXIMUS, *Federal Child Care Summary*, 1991 (unpublished). This table compares a number of features of the principal child care support programs administered by the Department of Health and Human Services.

8. U.S. Department of Health and Human Services, Children's Bureau, *A Guide to Funding Resources for Child Abuse and Neglect and Family Violence Programs*, (DHHS Publication No. (ACF) 91-30345, 1991), 68 pages. This guide appears to cover all of the federal sources of funding for these programs comprehensively, and it provides some references to state government and organization contacts as well.

9. U.S. Government Printing Office (Looseleaf, updated periodically). *Catalogue of Federal Domestic Assistance*. This service is available in all Federal Depository Libraries, and it summarizes each federal government program that provides assistance within the United States. The advantages of this source are its comprehensiveness, its authenticity, and its description of each federal program. The drawbacks are that the categories used rarely match what you are interested in, and the indexing system leaves much to be desired.

10. U.S. House of Representatives, Select Committee on Children, Youth, and Families (1990). *Federal Programs Affecting Children and their Families, 1990*. This source provides much more helpful descriptions and comparative analyses of federal children's assistance programs than the *Catalogue of Federal Domestic Assistance*. It is dated, however.

11. U.S. Office of Management and Budget, *Child Care Program Summaries* (1988, unpublished). These 1-page summaries of each program affecting child care financially were prepared for use in connection with the child care bill then pending. They provide the best cost breakdown available about the child care portion of the Federal programs that include, but are not limited to, child care.

B. OTHER SOURCES

1. Gina Adams for Children's Defense Fund (1992) *State Investments in Child Care*. This relatively short but fact-packed report summarizes and compares the state governments' princi-

pal programs of support for child care and finds a dramatic variation between states in how much money they put into child care, and which programs they favor ($4.50).

2. Matia Finn, National Association for the Education of Young Children (1982) *Fundraising for Early Childhood Programs: Getting Started and Getting Results.* This small (76-page) and inexpensive ($3.50) book, now in its third printing, is full of practical advice directed to child care professionals, about how to get established as a nonprofit organization and how to obtain contributions from a variety of sources. The fundraising "game" is even more professional and organized than when this book was written, but most of it is still quite timely.

3. Mary Hall, Portland State University (1988) *Getting Funded: A Complete Guide to Proposal Writing.* This gives practical advice about developing proposals, from the pre-proposal phase where ideas and funding sources are explored to the proposal phase, including suggestions on writing the proposal, the statement of need, the purpose of the proposal, the procedures for handling it, its evaluation, the dissemination of the proposal, and other details.

4. National Register (1992). *Annual Register of Grant Support.* This provides detailed information on over 3,000 organizations that have grant support programs in various areas. It includes descriptions of many types of grants and of how to plan and write proposals.

5. Annie L. New (1990) for The Foundation Center. *Raise More Money for your Nonprofit Organization: A Guide to Evaluating and Improving Your Fundraising* ($14.95). This guidebook is divided into three sections: preparations for a fundraising campaign, methods to mobilize many sources of funding, and a 20-page bibliography on funding research and directories.

6. Resources for Children with Special Needs (1989) *Family Support Services: A Guide for Children with Special Needs and Their Families.*

7. Michael Seltzer (1987) for the Foundation Center. *Securing Your Organization's Future: A Complete Guide to Fundraising Strategies* ($24.95). This guide to fundraising provides case studies and facts to demonstrate step-by-step approaches to financial security through a wide network of support from funding sources. Worksheets and a bibliography are included.

8. The Foundation Center (1990) *National Guide to Funding for Children, Youth and Families.* This expensive ($125) but comprehensive (753 pages) source provides information needed by

virtually anyone seeking a grant from a public foundation for child-related work. The Foundation Center, which publishes it, operates offices in the major cities that are repositories of information on foundation grants and how to ask for them.

APPENDIX F

■

SELECTING QUALITY CHILD CARE

CAROL ANN BAGLIN

SELECTING QUALITY CHILD CARE

Family day care providers and child care centers should encourage parents to ask questions and spend time visiting the child care setting and observing the care provided. At a minimum, child care in family day care homes and child care centers must meet the requirements of the state or local government. In addition, there are certain quality indicators which are important in evaluating care. The following issues should be addressed with potential providers in selecting child care for young children.

LICENSING Does the center or home have a license or registration? It should be displayed and prospective applicants should request to see it. Has the licensee been involved in any hearings regarding their license (check with state licensing agency)?

HEALTH AND SAFETY ISSUES Are the bathroom facilities visible and carefully monitored by two or more adults? Are children supervised at all times? How do children use the bathroom facilities during outdoor play? Are there policies for the care of ill children? Do all children have proof of current vaccinations? Does the facility have a pediatrician available for emergencies? Are all accidents reported in writing to the parents? Is the staff trained in CPR? Is there a first aid kit available? Is there fire safety equipment in good working order? Does the facility or home have liability insurance?

ACCESS Is there full access during hours of operation? Does the facility have a drop-in policy for parents? Is there pressure to avoid certain periods of the day? Is there protection from indiscriminate public access? Is there a method to monitor access to the center by the general public and delivery persons?

COMMUNICATION How do parents contact the teacher? Are there regular parent meetings or parent training efforts? Is there a newsletter? How can the director be reached after hours of operation if there are concerns? Is the full name of the teacher provided and a regular means of contact available? Are there policies on who can pick up the children?

METHODS OF DISCIPLINE How are children disciplined? Under what circumstances is corporal punishment used? When there are problems are parents promptly notified? Does the facility or provider use time out? Inspect the area and indicate family discipline practices in writing.

STAFF-CHILD RATIO Is there sufficient staff to not only meet state standards but provide interactive relationships with the

children? Are children grouped with appropriately qualified staff? Are staff available in sufficient numbers for coverage during lunch and breaks?

NUTRITION Who provides the food? Are there snack periods? How many adults are available to assist with feeding the infants? Are there high chairs available for infants which are safe and clean? Is self-feeding an option for toddlers? If the child has feeding difficulties, are their adults trained in specialized feeding techniques? Is food consumption reported to the parent, particularly for infants? What is the equipment cleaned with and how often?

STAFF POLICIES Does the director have training, a degree, or certificates related to caring for children? Are the staff certified? Are there ongoing training opportunities for staff in early childhood development? What is the staff-child ratio? What are the policies on substitutes? Are parents notified about staff changes? Have there been criminal background checks on all staff, including kitchen and custodial? Are the names of the staff available to check with the police for prior felonies or with the motor vehicle administration for driving record? Do the staff have appropriate expectations for young children?

FIELD TRIPS Do children go on field trips? Are vehicles equipped with child safety restraints? Are parents always notified when children are removed from the site? If the family child care provider transports children to other programs, who supervises the remaining children?

COSTS Are costs available in written material? What are the policies concerning holiday and sick days? What about long-term illness or family vacations? Are there sliding fee scales? Is the social security number of the facility or family day care provider available for tax purposes?

OUTDOOR ACTIVITIES Is there a safe outdoor play area? Is there always supervision during outdoor activities? What if children need to use the bathroom? What activities are available during inclement weather? Are the outdoor equipment and toys safe and in good working order?

USE OF TELEVISION If there is a regular period for television viewing, when is it? How long? What programs are watched? Do teachers discuss the program and use it within a meaning meaningful context? Are children required to watch television?

DAILY ACTIVITIES/CURRICULUM Is there a daily plan of developmentally appropriate activities? How are children grouped? Do the staff use paper and pencil or stress interactive group activi-

ties? Are checklists used for developmental inventories? Can parents obtain copies?

STAFF INTERACTIONS Do the staff interact positively with the children? Do the staff assist the children with activities or are they directive and demanding of the children? Are children able to demonstrate respect for themselves and others?

NAPTIME Is there a regular period for napping? How long? Who supervises the children? Are cots provided and is the area visible and accessible? Can the parent observe? What about monitors?

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